PSYCHOLOGICAL FIRST AID
Field Operations Guide

Medical Reserve Corps
National Child Traumatic Stress Network
National Center for PTSD

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Psychological First Aid

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Introduction and Overview
Psychological First Aid in Medical Reserve Corps Setting

The Medical Reserve Corps Edition of PFA

The Medical Reserve Corps (MRC), one of the newest organizations in the disaster response community, has evolved rapidly since its creation in 2002, by the Office of the Surgeon Gene United States Public Health Service (USPHS). Now with more than 400 individual units and o 73,000 members, MRCs are rapidly becoming the most prominent vehicle for pre-registering credentialing and training health and mental health professional volunteers in disaster respo

As the program evolved, it became clear that individual MRC units were seeking assistance i interpreting best practices and developing response guidelines across a host of operational a Taking this feedback, the national Program Director, Commander Rob Tosatto, USPHS, initiate several work groups to help identify some common guidelines and standard tools for MRC un consider, while at the same time respecting the local autonomy of the individual unit. One o areas of focus is disaster mental health.

The National MRC Mental Health Work Group has examined the field of disaster mental healt reviewed a host of issues with the intent of providing guidance to local MRC units on areas o competence, the availability of existing training curricula, voids in service delivery and contr in the field. As one of its first actions, the National MRC Mental Health Work Group is recommending 'Psychological First Aid' as a standard model of mental health intervention in response to disasters and other traumatic events. We believe this Guide and direction helps major gap in the field by helping to standardize and clarify the concepts of 'Psychological Fir one of the few evidence-driven intervention strategies in disaster mental health response.

What is Psychological First Aid?

Psychological First Aid is an evidence-informed[1] modular approach to assist children, adolescents, adults, and families in the immediate aftermath of disaster and terrorism.[2] Psychological First Aid is designed to reduce the initial distress caused by traumatic events, and to foster short- and l adaptive functioning and coping. Principles and techniques of Psychological First Aid meet f standards. They are: (1) consistent with research evidence on risk and resilience following tr applicable and practical in field settings; (3) appropriate to developmental level across the li (4) culturally informed and adaptable. Psychological First Aid does not presume all survivors develop severe psychopathology, but instead fosters an understanding that disaster survivo others impacted by such events, will experience a broad range of reactions (e.g. physical, psychological, cognitive, spiritual). Some of these reactions will cause sufficient distress for individual and may be alleviated by support from compassionate and caring disaster respon Psychological First Aid is an intervention strategy that can be woven into the basic disaster r mechanisms for MRC units.

Who is Psychological First Aid For?

[1] PFA has received considerable support from disaster mental health experts in the field as the 'acute intervent when responding to the psychological, psychosocial, and psychospiritual needs of individuals impacted by disa important to note, however, no model of PFA to date has been empirically validated or rigorously tested and th efficacy of this supportive intervention and its resultant outcomes are unknown. Because many of the compon have emanated from other theoretical models of support that have been tested and validated, there is consens experts at this time that these components when administered to disaster survivors and workers individually sh worse produce no harm, and at best, provide effective ways for individuals to manage post-disaster stress and who may require additional psychological support.

[2] While this guide primarily focuses on the use of PFA in a disaster survivor population, this support interventio be used with disaster workers and other relief personnel.

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Psychological First Aid intervention strategies are intended for use with children, adolescents parents/caretakers, families, and adults. Other populations include healthcare workers, law enforcement officers, firefighters, emergency medical service professionals, and other first r and disaster relief workers.

Who Delivers Psychological First Aid?

Psychological First Aid is designed for delivery by a variety of response units. All members o MRC who provide acute assistance as part of the organized disaster response effort should b in the basics of providing PFA. These providers may be imbedded in a variety of response un including first responder teams, incident command systems, primary and emergency health providers, school crisis response teams, faith-based organizations, Community Emergency R Teams (CERT), Medical Reserve Corps, the Citizens Corps, and disaster relief organizations.

When Should Psychological First Aid Be Used?

PFA is a supportive behavioral intervention for use in the immediate aftermath of disasters a traumatic events. It is intended to blend into the general MRC response structure early in di stabilization and recovery efforts.

Where Should Psychological First Aid Be Used?

Psychological First Aid is designed for delivery in diverse settings. Medical Reserve Corps m may be called upon to provide PFA in general population shelters, special needs shelters, fie hospitals and medical triage areas, acute care facilities (e.g., Emergency Departments), stag respite centers for first responders or other relief workers, emergency operations centers, cr or phone banks, feeding locations, disaster assistance service centers, family reception and centers, homes, businesses, and other community settings. Following weapons of mass des (WMD) events or other such public health emergencies, Psychological First Aid may be delive fatality collection points and in locations providing decontamination or mass prophylaxis ser information on the challenges of providing PFA in some of these service sites, see Appendix

Strengths of Psychological First Aid

- Psychological First Aid includes basic information-gathering techniques to help mental h specialists make rapid assessments of survivors' immediate concerns and needs and ho implement supportive activities in a flexible manner.
- Psychological First Aid relies on field-tested, evidence-informed strategies that can be p in a variety of disaster settings.
- Psychological First Aid emphasizes developmentally and culturally appropriate intervent survivors of various ages and backgrounds.
- Psychological First Aid includes important elements of risk communication and educatio the use of materials and handouts that provide information for youth, adults, and famili their use over the course of recovery in contending with post-disaster reactions and adv

Basic Objectives of Psychological First Aid

- Establish a human connection in a non-intrusive, compassionate manner.
- Enhance immediate and ongoing safety, and provide physical and emotional comfort.
- Calm and orient emotionally-overwhelmed or distraught survivors.
- Help survivors to articulate immediate needs and concerns, and gather additional inform appropriate.
- Offer practical assistance and information to help survivors address their immediate nee concerns.
- Connect survivors as soon as possible to social support networks, including family mem friends, neighbors, and community helping resources.

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- Support positive coping, acknowledge coping efforts and strengths, and empower surviv
  encourage adults, children, and families to take an active role in their recovery.
- Provide information that may help survivors to cope effectively with the psychological in
  disasters.
- Facilitate continuity in disaster response efforts by clarifying how long the Psychological
  Aid provider will be available, and (when appropriate) linking the survivor to another me
  a disaster response team or to indigenous recovery systems, mental health services, pu
  services, and organizations.

Delivering Psychological First Aid

Professional Behavior

- Operate only within the framework of an authorized disaster response system.
- Model sound responses; be calm, courteous, organized, and helpful.
- Be visible and available.
- Maintain confidentiality as appropriate.
- Remain within the scope of your expertise and your designated role.
- Make appropriate referrals when additional expertise is needed or requested by the indi
- Be knowledgeable and sensitive to issues of culture and diversity.
- Pay attention to your own emotional and physical reactions, and actively manage these

Guidelines for Delivering Psychological First Aid

- Politely observe first, don't intrude. Then ask simple respectful questions, so as to be a
  discuss how you may be of help.
- Initiate contact only after you have observed the situation and the person or family, and
  determined that contact is not likely to be an intrusion or disruptive.
- Be prepared to be either avoided or flooded with contact by affected persons, and make
  respectful contact with each person who approaches you.
- Speak calmly. Be patient, responsive, and sensitive.
- Speak in simple, concrete terms; don't use acronyms or responder 'jargon'. If necessary
  slowly.
- If survivors want to talk, be prepared to listen. When you listen, focus on learning what
  want to tell you and how you can be of help.
- Acknowledge the positive features of what the person has done to keep safe and reach
  setting.
- Adapt the information you provide to directly address the person's immediate goals and
  answers repeatedly as needed.
- Give information that is accurate and age-appropriate for your audience, and correct ina
  beliefs. If you don't know, tell them this and offer to find out.
- When communicating through a translator or interpreter, look at and talk to the person
  addressing, not at the translator or interpreter.
- Remember that the goal of Psychological First Aid is to reduce distress, assist with curre
  and promote adaptive functioning, not to elicit details of traumatic experiences and loss

Working With Children and Adolescents

- Sit or crouch at a child's eye level.
- Help children verbalize their feelings, concerns and questions; provide simple labels for c
  emotional reactions (e.g., mad, sad, scared, worried). Match the children's language to h
  connect with them, and to help them to feel understood and to understand themselves.
  increase their distress by using extreme words like "terrified" or "horrified."

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- Match your language to the child's developmental level. Children 12 years and under typ
  have much less understanding of abstract concepts and metaphors compared to adults. U
  and simple language as much as possible.
- Adolescents often appreciate having their feelings, concerns and questions addressed as
  rather than child-like responses.
- Reinforce these techniques with the child's parents to help them provide appropriate emo
  support to their children.

Some Behaviors to Avoid

- Do not make assumptions about what the person is experiencing or what they have bee
- Do not assume that everyone exposed to a disaster will be traumatized.
- Do not pathologize. Most acute reactions are understandable and expectable given wha
  exposed to the disaster have personally experienced. Do not label reactions as 'sympto
  speak in terms of "diagnoses," "conditions," "pathologies," or "disorders."
- Do not talk down to or patronize the survivor, or focus on their helplessness, weaknesse
  mistakes, or disability. Focus instead on what the person has done that is effective or m
  contributed to help others in need, both during the disaster and in the present setting.
- Do not assume that all survivors want to talk or need to talk to you. Often, being physic
  present in a supportive and calm way helps affected people to feel safer and more able
- Do not "debrief" by asking for details of what happened.
- Do not speculate or offer erroneous or unsubstantiated information. If you don't know s
  that you are asked, do your best to learn the correct facts.
- Do not suggest fad interventions or present uninformed opinion as fact.

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Preparing to Deliver Psychological First Aid

In order to be of assistance to disaster-affected communities, the provider must be knowledg
about the nature of the event, the post-event circumstances, and the type and availability o
support services.

Pre-planning and Preparation

Pre-planning and preparation becomes particularly important when working as an MRC mem
uniqueness of the MRC in regard to the variety of units' roles and response duties provides f
flexible resource, but pose potential communication problems unless thought about and reso
of time. Prior knowledge of professional competencies (expectations and limitations), agree
response guidelines, organizational control, incident command structure and working guideli
other 'partner' agencies is critical to a cooperative and functional MRC response. As MRC m
we can look to our local leadership for pre-event exercises and interagency drills to help bric
important differences. Flexibility, open-mindedness and cooperation will be highly regarded
early in the response.

Entering the Setting

Psychological First Aid begins when a disaster mental health specialist enters an emergency
management setting in the aftermath of a disaster (See Appendix A for examples of various
delivery sites). Successful entry involves working within the framework of an authorized Inc
Command System (ICS) in which roles and decision-making are clearly defined. It is essenti
establish communication and coordinate all activities with authorized personnel or organizat
are managing the setting. Effective entry also involves orienting yourself to the setting (e.g
leadership, organization, policies and procedures, security, psychiatric support) and availabl
As you provide Psychological First Aid, you need to have accurate information about what is
happen, what services are available, and where services can be found. This information nee
gathered as soon as possible, given that providing such information is often critical to reduci
and promoting adaptive coping.

Providing Services

In some settings, Psychological First Aid may be provided in designated areas. In other setti
Psychological First Aid providers may circulate around the facility to identify those to be app
for assistance. Focus your attention on how people are reacting and interacting in the settin
Individuals who may need assistance include those showing signs of acute distress. This inc
individuals who are:

- Disoriented
- Confused
- Frantic
- Panicky
- Extremely withdrawn, apathetic or "shut down"
- Extremely irritable or angry
- Individuals who are exceedingly worried

Decide who may need assistance or would benefit most from contact with you, and plan for
contact them within the time and constraints of the setting.

Maintain a Calm Presence

People take their cue from how others are reacting. By demonstrating calmness and clear th
you can help survivors feel that they can rely on you. Others may follow your lead in remain
focused, even if they do not feel calm, safe, effective, or even hopeful. Psychological First A
providers often model the sense of hope that affected persons cannot always feel while they
attempting to deal with what happened and current pressing concerns.

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Be Sensitive to Culture and Diversity

Sensitivity to culture and ethnic, religious, racial, and language diversity is central to providi
Psychological First Aid. It is critical to both outreach efforts and service provision. Providers
be aware of their own values and prejudices, and how these may coincide or differ with thos
community being served. Helping to maintain or reestablish customs, traditions, rituals, fam
structure, gender roles, and social bonds is important to helping survivors cope with the imp
disaster. Information about the community being served, including how emotions and other
psychological reactions are expressed, attitudes towards governmental agencies, and recept
counseling, should be gathered with the assistance of community cultural leaders who repre
best understand local cultural groups.

Be Aware of At-Risk Populations

Individuals that are at special risk after a disaster include:

- children (especially children whose parents have died, were significantly injured or are
  missing)
- those who have had multiple relocations and displacements
- medically frail adults
- the elderly
- those with serious mental illness
- those with physical disabilities or illness
- adolescents who may be risk-takers
- adolescents and adults with substance abuse problems
- pregnant women
- mothers with babies and small children
- professionals or volunteers who participated in disaster response and recovery efforts
- those who have experienced significant loss of their possessions (e.g., home, pets, far
  memorabilia, etc.)
- those exposed first hand to grotesque scenes or extreme life threat

The prevalence of exposure to pre-disaster trauma may be higher among economically disad
populations. As a consequence, minority and marginalized communities may have higher ra
disaster trauma-related mental health problems, and are at greater risk for developing probl
following disaster. Mistrust, stigma, fear (e.g., fear of deportation), and lack of knowledge a
disaster relief services are important barriers to seeking, providing, and receiving services fo
populations. Those living in disaster-prone regions are more likely to have had prior disaster
experiences, although having dealt well with a disaster in the past may be helpful in the cur
situation.

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Psychological First Aid Core Actions

1. Contact and Engagement
Goal**:** To respond to contacts initiated by affected persons, or initiate contacts in a non-intrus
compassionate, and helpful manner.

2. Safety and Comfort
Goal: To enhance immediate and ongoing safety, and provide physical and emotional comfo

3. Stabilization (if needed) **1**
Goal: To calm and orient emotionally-overwhelmed/distraught survivors.

4. Information Gathering: Current Needs and Concerns
Goal: To identify immediate needs and concerns, gather additional information, and tailor
Psychological First Aid interventions.

5. Practical Assistance
Goal: To offer practical help to the survivor in addressing immediate needs and concerns.

6. Connection with Social Supports
Goal: To help establish brief or ongoing contacts with primary support persons or other sourc
support, including family members, friends, and community helping resources.

7. Information on Coping
Goal: To provide information (about stress reactions and coping) to reduce distress and prom
adaptive functioning

8. Linkage with Collaborative Services
Goal: To in form and link survivors with available services needed at the time or in the future

These core goals of Psychological First Aid constitute the basic objectives of providing early
assistance (e.g., within days or weeks following an event) and will need to be addressed in a
way, using strategies that meet the specific needs of children, families and adults. The amo
spent on each goal will vary from person to person, and with different circumstances accord
need.

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1. Contact and Engagement

Goal: To respond to contacts initiated by affected persons, or initiate contacts in a compassionate, and helpful manner.

The first contact with a survivor is important. If managed in a respectful and compassionate can help establish an effective helping relationship and increase the person's receptiveness help. Your first priority should be to manage contacts with persons who seek you out, espec number of people approach you simultaneously. Make contact with as many individuals as y Often this will be very brief, but even a brief look of interest and calm concern from another can be grounding and helpful to people who are feeling detached or overwhelmed.

Culture Alert: **The type of physical or personal contact that is appropriate may va person to person and across cultures and social groups, for example, how close to someone, how much eye contact to make or how acceptable it is to touch someon should look for clues to a survivor's need for "personal space," and be informed a cultural norms through community cultural leaders who best understand local cus**

Others will not seek your help but may benefit from assistance. When you identify such per timing is important. Do not interrupt conversations. You may try to make nonverbal contact by returning eye contact). *Do not assume* that people will respond to your assistance with i positive reactions. It may take time for some survivors or bereaved persons to feel some de safety, confidence and trust. If an individual declines your offer of help, respect his/her deci indicate when and where Psychological First Aid providers will be available later on.

Introduce Yourself/Ask about Immediate Needs

Introduce yourself with your name and title, and describe your role. Ask for permission to ta them, and explain your objective of finding out whether there is anything you can do to mak easier, or helping with ways to help themselves feel better. Unless given permission to do o address adult survivors using last names. Invite the person to sit, try to ensure some level o for the conversation, and give the person your full attention. Speak softly and calmly. Refra looking around or being distracted. Find out whether there is any pressing problem that nee *immediate attention*. Immediate medical concerns have the utmost priority.

Adult/ Caregiver	Hello. My name is _____. I work with _____. I'm checking in with people to see how they are doing, and to see if I can help in any way. Is it okay if I talk to you for a few minutes? May I ask your name? Mrs. Williams, before we talk, is there something right now that you need, like some water or fruit juice?
Adolescent/ Child	And is this your daughter? (Get on child's eye level, smile and greet the child, using her/his name and speaking softly.) Hi Lisa, I'm _____ and I'm here to try to help you and your family. Is there anything you need right now? There is some water and juice over there, and we have a few blankets and toys in those boxes.

When making contact with children or adolescents, it is good practice to make a connection parent or accompanying adult to explain your role and seek permission. When speaking wit in distress when no adult is present, it is important to find a parent or caregiver to let them k your conversation.

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2. Safety and Comfort

Goal: Enhance immediate and ongoing safety, and provide physical and emotional

Restoration of a sense of safety is an important goal in the immediate aftermath of disaster. and a sense of safety can be supported in many ways. Some strategies to accomplish this i

- Do things that are active (rather than passive waiting), practical (using available resou familiar (drawing on well-learned behaviors that do not require new learning) can incre sense of control over the situation.
- Get current accurate and up-to-date information, while avoiding exposure to inaccurat traumatizing information via media, official updates, and informal conversations.
- Get connected with immediate practical resources (ways to connect with loved ones).
- Get information that is focused on how responders are making the situation safer.
- Be connected with others who have shared similar experiences.

Ensure Immediate Physical Safety

Make sure that individuals and families are physically safe to the extent possible in the situa hand. If necessary, re-organize the immediate environment to increase *physical* and *emotio* For example:

- Find the appropriate officials who can resolve safety concerns that are beyond your to control, such as threats, weapons, etc.
- Remove broken glass, sharp objects, furniture, spilled liquids and other objects that cause people to trip and fall.
- Place barriers to prevent intrusions by unauthorized persons.
- Make sure that persons who may be at risk for falling (i.e, physically frail individuals in areas that don't require the use of stairs or are located in lower levels of the shel

If there are medical concerns requiring urgent attention, contact the appropriate unit leader support immediately. Remain with the affected person or find someone to stay with the affe person until help can be obtained. Other safety concerns involve:

- *Threat of harm to self or others* - Look for signs that persons may hurt themselves or o (e.g., expresses intense anger towards self or others, exhibit extreme agitation). If so, immediate support for containment and management by medical, EMT assistance, or a team.
- Shock - If an individual is showing signs of shock (pale, clammy skin, weak or rapid pu irregular breathing, dull or glassy eyes, unresponsive to communication, lack of bladde bowel control, restless or agitated), seek immediate medical support.

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Enhance Sense of Predictability, Control, Comfort, and Safety

Information can help to re-orient and comfort children and families, and can include informa about:

- What to do next
- What is being done to assist them
- What is currently known about the unfolding event
- Available services
- Stress reactions
- Self-care, family care, and coping

In providing information:

- Use your judgment as to whether and when to present information. Does the individu able to comprehend what is being said, and is he or she ready to hear the content of t messages?
- The most useful information is that which provides assistance in addressing immediate reduces fears, answers pressing questions, addresses current concerns, and supports efforts.
- Use clear and concise language, while avoiding technical jargon.

Provide Simple Information about Disaster Response Activities and Services

Ask survivors if they have any questions about what is going to happen, and give simple acc information about what they can expect. *Be sure to ask about concerns regarding current da safety in their new situation*. Try to connect survivors with information that addresses these If you do not have specific information, *do not* guess or invent information in order to provid reassurance. Instead, develop a plan with the person for ways you and he/she can gather th information. Examples of what you might say include:

Adult/ Caregiver/ Adolescent	From what I understand, we will start transporting people to the shelter at West High School in about an hour. There will be food, clean clothing, and a place to rest. Stay in this area. A member of the team will look for you here when we are ready to go.
Child	Here's what's going to happen next. You and your mom are going to go together soon to a place called a shelter, which really is just a safe building with food, clean clothing, and a place to rest Stay here close to your mom until people are ready to go.

Do not reassure people that they are safe *unless you have definite factual information that case*. Also do not reassure people of the availability of goods or services (e.g., toys, food, m etc.) unless you have definite information that such goods and services will be available. For you may say:

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Adult/ Caregiver	Mrs. Williams, I want to assure you that you are in good hands. The fire has bee contained, and you and your family are not in danger from the fire. Do you hav any concerns about your family's safety right now?
Adolescent	We're working hard to make you and your family safe. Do you have any questions about what happened, or what is going to be done to keep everyone safe?
Child	Your mom and dad are here, and many people are all working hard together so that you and your family will be safe. Do you have any questions about what we're doing to keep you safe?

Attend to Physical Comfort

Look for simple ways to make the physical environment more comfortable. If possible, cons things like temperature, lighting, air quality, access to furniture, and how the furniture is arra order to reduce feelings of helplessness or dependency, encourage affected persons to parti getting things needed for comfort (e.g., offer to walk over to the supply area with the perso than retrieving supplies for them). Help them regain or exercise their ability to soothe and c themselves and others around them. For children, toys like soft Teddy Bears that they can h take care of, can help them to soothe themselves (Note: avoid offering such toys if there are enough to go around to all children who may request them) . You can help them learn how t of themselves by explaining how they can "care" for their toy, (e.g., "Remember that she ne drink lots of water and eat three meals a day – and you can do that too.")

Promote Social Engagement

Facilitate proximity to other people as appropriate. It is generally soothing and reassuring to other people who seem to be coping adequately with the situation. On the other hand, it is being near others who appear very agitated and emotionally overwhelmed. If they have hea worrying information from others or circulating rumors, help to clarify these and correct misinformation.

Children, and to some extent adolescents, are particularly likely to look to adults for cues ab and appropriate behavior. When possible, place children near adults or peers who appear rel calm given the circumstances, and shield them from close proximity to highly distressed ind Offer brief explanations to children and adolescents who have observed extreme reactions i survivors.

Child/ Adolescent	"That man is so upset that he can't calm down yet. Someone from our team is trying to help him calm down."

As appropriate, encourage people who are coping adequately to talk with others who are cu distressed or not coping as well. Those coping adequately may have concerns about being l by others' fears and anger. However, you can reassure them that talking to people, especia conversation focuses on things that people hold in common (for example, coming from near neighborhoods or sharing new information), can help them support one another. This often sense of isolation and helplessness in both parties. If feasible, provide access to age-approp materials that foster soothing activities. For children, encourage social activities like reading doing a joint art activity, and playing cards, board games, or sports.

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Attend to Children Who Are Separated from their Parents

Parents play a crucial role in children's perceived sense of safety following disasters. In the e children are separated from their parents, helping them reconnect quickly is a priority. Try to create a sense of security for children while their parents are being located or during periods where parents may become emotionally overwhelmed and are thus not emotionally accessib children.

For children separated from parents, help to create a designated child-friendly space. This c corner or room, ideally separate from rescue activities, warm, and with one door to control t come in and out. Pre-prepared kits with toys, paper and markers, books, etc. are helpful. Ex calming, soothing, reassuring activities that have been found to be useful are playing with L other basic building materials, using play dough, doing cut-outs or other simple art projects the hands busy, and working on coloring books (containing neutral scenes of flowers, rainbo or cute animals). Arrange for this space to be staffed with providers who are known and res who can help supervise activities that foster engagement, active interaction, and education appropriate developmental level. That person should be able to promote calmness among t children. Older children may be engaged as mentors/role models for younger children, as ap Do not make any promises that you may not be able to keep, such as promising that they wi their parents soon. Do provide accurate information in easy-to-understand terms so that the will know who will be supervising them and what activities to expect next.

In addition to securing the children's physical safety, it is also important to protect them fron to additional traumatic stimuli including sights, sounds, or smells that may be frightening. C psychologist working with a fire department described how responders would use their big y coats to help shield the child from traumatic sights while leading them to a safe place. The " analogy is an important one to keep in mind, as you will temporarily become that cover for t Use this time to find out the children's names, state your understanding of the situation, and them that you are taking them to a safe place while adults work to connect them with their f

In selecting a safe place for the children to rest while family members are located, think aga shielding them with a 'big coat'. Try to find a place that is out of high-traffic areas. Even if y positioned away from the injured and dead, children are likely to become distressed watchin rush around in their rescue efforts. Finding rooms or structures to serve as walls can protect from traumatic stimuli as well as help them focus on calming and reassuring activities.

Protect from Additional Traumatic Experiences and Trauma Reminders

Protect survivors from unnecessary exposure to additional trauma and trauma reminders (e. exposure to the suffering of others). Psychological First Aid providers should look for ways to minimize additional distressing experiences. When necessary, try to shield survivors from re other media professionals, onlookers or attorneys. Help protect their privacy.

If survivors have access to media coverage (e.g., television or radio broadcasts), point out th excessive viewing of such coverage can be highly upsetting, especially for children and adol Encourage parents to monitor and limit their children's exposure to the media, and discuss t children's concerns after such viewing. Parents can let their children know that they are kee of information from the media, and that children can get this information from them so that need to watch television. Remind parents to be careful about what they say in front of their and to clarify things that might have upset them.

Adult/ Caregiver	"You've been through a lot, and it's a good idea to shield yourself and your children from further frightening or disturbing sights and sounds as much as possible. Even televised scenes of the disaster can be very disturbing to childr Sometimes children worry that the disaster is happening all over again. You ma

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	find that your children feel better if you limit their television viewing of the disaster. It doesn't hurt for adults to take a break from all the media coverage, too."
Child and Adolescent	"You've been through a lot already. People often want to watch TV or look for information on the internet after something like this, but this can be pretty scar It's best to stay away from TV or radio programs that show this stuff. You can also tell your mom or dad if you see something that bothers you."

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3. Stabilization (if needed)

Goal: To calm and orient emotionally-overwhelmed or disoriented survivors.

Most individuals affected by a disaster or other traumatic incident will not require stabilizatio
Expressions of strong emotions, even muted emotions (e.g., numb, indifferent, spaced-out, c
confused), are expectable reactions to disaster, and do not of themselves signal the need fo
intervention beyond ordinary supportive contact.

Stabilize Emotionally-Overwhelmed Survivors

Observe individuals for signs of being disorientated or overwhelmed. Signs include:

- Looking glassy eyed and vacant – unable to find direction
- Unresponsiveness to verbal questions or commands
- Disorientation (e.g., engaging in aimless disorganized behavior)
- Exhibiting strong emotional responses, uncontrollable crying, hyperventilating, rocking regressive behavior
- Experiencing uncontrollable physical reactions (shaking, trembling)
- Exhibiting frantic searching behavior
- Feeling incapacitated by worry
- Engaging in risky activities

If the person is too upset, agitated, withdrawn, or disoriented to talk, or shows extreme anxi
panic, the Psychological First Aid provider should consider:

- Is the person alone or in the company of family and friends? If family or friends are present, it may be helpful to enlist their aid in comforting or providing emotional su the distressed person. Alternatively, you may take a distressed individual aside to place, or speak quietly with that person while family/friends are nearby.
- What is the person experiencing? Is he/she crying, panicking, experiencing a "flash or imagining that the event is taking place again? When intervening, address the p primary immediate concern or difficulty, rather than simply trying to convince the p "calm down" or to "feel safe" (neither of which tend to be effective).

For children or adolescents, consider:

- Is the child or adolescent with his/her parents? If so, briefly assess the situation to sure that the adult is coping. Focus on empowering the parents in their role of caln children. Do not move in and supplant the parents, and be careful to avoid making comments that may undermine the parents' authority or ability to handle the situat them know that you are available to assist in any way that they find helpful.
- If emotionally-overwhelmed children or adolescents are separated from their paren their parents are not coping well, refer below to the options for stabilizing distresse persons.

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Options for stabilizing distressed persons include:

- Respect the person's privacy, and give him/her a few minutes alone. Tell them that yo available if they need you or that you will check back with them in a few minutes to se they are doing and if there's anything you can do to help at that time.
- Remain present, and offer a drink or chair, rather than trying to talk directly to the per this may contribute to cognitive/emotional overload. Make small talk, talk to other pe the vicinity, do some paperwork, or in other ways demonstrate that you are occupied w tasks but available should the person need or wish to receive further practical or emot help.
- Offer support and help him or her focus on specific manageable feelings, thoughts, an

Talking Points for Emotionally-Overwhelmed Survivors

Adults or Caregivers

- Intense emotions may come and go like waves.
- Shocking experiences trigger strong and healthy, but often upsetting, self-protective "ala reactions in the body.
- Sometimes the best way to recover is to take a time-out (e.g., breathe deeply, go for a w
- Friends and family are very important sources of support to help you calm down.

Children and Adolescents

- These feelings come and go like waves in the ocean. When you feel really bad, that's a g to talk to your mom and dad to help you calm down.
- Even adults need help at times like this.
- Many adults are working together to respond to the disaster and to help people who were
- Staying busy can help you deal with your feelings and start to make things better.
- Caution adolescents about doing something quickly just to feel better, without discussing parent or trusted adult.

Adolescent/ Child	"Is there anyone who helps you feel better when you talk to them? Maybe I can help you get hold of them." "You are doing a great job of letting grown-ups know what you need. It is important to keep letting people know how they can help you."

If the person appears extremely agitated, shows a rush of speech, seems to be losing touch surroundings, or is experiencing ongoing intense crying, it may be helpful to:

- Ask the individual to listen to you and look at you.
- Find out if they know who they are, where they are, and what is happening.
- Ask him/her to describe the surroundings, and say where both of you are.
- Clarify what has happened and the order of events (without graphic details).

A technique to help stabilize agitated children and adults is called 'grounding.' You can introd grounding by saying:

"After a frightening experience, you can sometimes find yourself overwhelmed with emotion unable to stop thinking about or imagining what happened." You can use a method called "g to feel less overwhelmed. Grounding works by turning your attention from your thoughts to outside world. Here's what you do…."

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•Sit in a comfortable position with your legs and arms uncrossed.
•Breathe in and out slowly and deeply.
•Look around you and identify five non-distressing things that you can *see*. Name each thing
mind, for example you could say, “I see the floor, I see a shoe, I see a table, I see a chair, I s
person.”
•Breathe in and out slowly and deeply.
•Next, identify five sounds you can *hear*. Name each thing in your mind. For example you c
“I hear a woman talking, I hear myself breathing, I hear a door close, I hear someone typing
cell phone ringing.”
•Breathe in and out slowly and deeply.
•Next, identify five things you can *feel*. Name each thing in your mind. For example, you co
“I can feel this wooden armrest with my hands, I can feel my toes inside my shoes, I can fee
pressing against my chair, I can feel the blanket in my hands, I can feel my lips pressed toge
•Breathe in and out slowly and deeply.

If none of these interventions aids in emotional stabilization, consultation with mental health
colleagues and/or psychiatric consultation for medication may be indicated.

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4. Information Gathering: Needs and Current Con

Goal: To identify immediate needs and concerns, gather additional information, ar Psychological First Aid interventions.

Gathering and clarifying information begins immediately after contact, and is ongoing throug Psychological First Aid (as appropriate). As immediate needs and concerns are identified an addressed, it is useful to gather and clarify additional information. Remember that in most Psychological First Aid service delivery contexts, time, survivors' needs and priorities, and ot factors will limit information gathering. However, although a formal assessment is not appro provider may ask pertinent questions to obtain and clarify a variety of issues that can inform about:

- Need for Immediate Referral
- Need for Additional Services
- Offering a Follow-up Meeting
- Using Components of Psychological First Aid that may be helpful

It may be especially useful for the provider to ask some questions to clarify the following:

Nature and severity of experiences during the disaster

Children, adolescents and adults who have had the most serious forms of exposure to direct to self or loved ones, injury to self, or witnessing injury or death may likely experience more and prolonged distress. Those who felt extremely terrified and helpless may also have more in recovering.

Information about this may be elicited with questions like:

Child and Adolescent	"I know that you've been through a lot of difficult things. Would it be helpful to talk about any of what you have been through? Where were you during the hurricane? Did you get hurt? Did you see anyone get hurt? How afraid were you?

Provider Alert: **In clarifying disaster-related traumatic experiences, the Psycholog First Aid provider should avoid asking for in-depth description of traumatic experi as this may provoke unnecessary additional distress. It is especially important to the lead of the survivor in discussing what happened during the event. Individual should not be pressed to disclose details of any trauma or loss. On the other hand individuals are anxious to talk about their experiences, let them know politely and respectfully that what would be most helpful now is to get some basic information able to help with what is currently needed and plan for future care. Let them know the opportunity to discuss their experiences in a proper professional setting can b arranged for the future.**

For people with these experiences, provide information about post-disaster reactions, inform about coping, and offer a follow-up meeting.

Death of a family member or close friend

Loss of loved ones under traumatic circumstances is devastating, and over time can greatly the grieving process.

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Information about loss may be elicited with a question like:

Adult/ Caregiver	"Did someone close to you get hurt or die as a result of the hurricane? What happened?"

For those with loss, provide emotional comfort, information about coping, information about support, information on traumatic grief and offer a follow-up meeting.

Concerns about immediate post-disaster circumstances and ongoing threat

Especially in regard to complicated emergencies, concerns over immediate and ongoing dan a major source of distress.

Information about this may be elicited with questions like:

Adult/ Caregiver	Do you need any information to help you better understand what has happened Do you need information about how to keep you and your family safe? Do you need information about what is being done to protect the public?

For those with these concerns, help with obtaining risk-related information.

Separations from or concern about the safety of loved ones

Separation from loved ones, and concern over their safety, constitute additional sources of d the aftermath of disaster. If not earlier addressed, information may be elicited with question these:

Adult/ Caregiver	Are you worried about anyone close to you right now? Do you know where they are? Is there anyone especially important like a family member or friend who is missing?

For survivors with these concerns, provide practical assistance to help locate and reunite fa members, or develop a strategy for seeking information about persons of concern.

Physical illness and need for medications

Pre-existing medical conditions and need for medications constitute additional sources of po distress and adversity. Immediate medical concerns need to be given a high priority.

Information about this may be elicited with questions like:

Adult/ Caregiver	Do you have any physical or medical condition that needs attention? Do you need any medications that you don't have? Do you need to have a prescription filled?

For those with medical conditions, provide practical assistance in obtaining medical care and medication. Connect with additional services if needed.

Losses incurred as a result of the disaster (home, school, neighborhood, business property, or pets)

Extensive material losses and their associated post-disaster adversities can significantly inte recovery, and are often be associated with feelings of depression, demoralization, and hopel over time.

Information about this may be elicited with questions like:

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Adult/ Caregiver	Was your home badly damaged or destroyed? Did you lose other important personal property? Did a pet die or get lost? Was your business, school, or neighborhood badly damaged or destroyed?

For those with losses, provide emotional comfort, practical assistance to help link with availa resources, information about coping, and information about social support.

Extreme feelings of guilt or shame

These extreme negative emotions can be very painful, difficult and challenging, especially fo and adolescents. Remember that children and adults may be ashamed to discuss these feel approach would be to listen carefully for signs of these emotions in their comments, then ma clarifying comments such as:

Adult/ Caregiver	It sounds like you are being really hard on yourself about what happened. It seems like you feel that you could have done more.

For those with these negative emotions, provide emotional comfort and information about co

Thoughts about causing harm to self or others

Disasters can evoke overwhelming feelings of grief, anxiety, depression, and anger. Getting whether an individual is having thoughts about causing harm to self or others should be han sensitively.

Information about this may be elicited with questions like:

Adult/ Caregiver	Sometimes situations like these can be very overwhelming for individuals. Have you had any thoughts about harming yourself? Have you had any thoughts about harming someone else?

For those with these thoughts, escort them to medical services.

Lack of adequate supportive social network

Lack of adequate family and community support can greatly interfere with the ability to cope distress and post-disaster adversity.

Information about this may be elicited with questions like:

Adult/ Caregiver	Are there family members, friends, or community agencies that you can rely on for help in dealing with problems you are facing as a result of the disaster?

For those in this situation, provide linkage with available resources and services, information coping, information about social support, and offer a follow-up meeting.

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Prior alcohol or drug use

> ***Provider Alert*: In clarifying prior history of substance use, prior trauma and loss, prior mental health problems (as in the sections below) the Psychological First Aid provider should be sensitive to the immediate needs of the survivor, avoid asking history if not appropriate, and avoid asking for in-depth description. It may be he to link the questions to clear reasons for asking (for example, "Sometimes events this can remind individuals of previous bad times..." "Sometimes individuals who alcohol to cope with stress will notice an increase in drinking following an event su this...").**

Exposure to trauma and post-disaster adversities can exacerbate ongoing substance use, ca of past substance abuse, or lead to new abuse.

Information about this may be elicited with questions like:

Adult/ Caregiver	Do you tend to use alcohol, prescription medications, or drugs as a way to cope with stress? Have you had any problems in the past with alcohol or drug use?

For those with potential substance use problems, provide information about coping, informat social support, link to appropriate services and offer a follow-up meeting.

Prior exposure to trauma and loss

Those with a history of exposure to trauma or loss may experience more severe and prolong disaster reactions, and a "rekindling" of prior trauma reactions.

Information about this may be elicited with questions like:

Adult/ Caregiver	Sometimes events like this can remind individuals of previous bad times. Have you ever been in a hurricane or other disaster before? Has some other bad thing happened to you in the past? Have you ever had someone close to you die?

For those with prior exposure, provide information about post-disaster reactions, information coping, and offer a follow-up meeting.

Prior psychological problems

Those with a history of psychological problems may experience an exacerbation of these pro more severe and prolonged post-disaster reactions.

Information about this may be elicited with a question like:

Adult/ Caregiver	Sometimes events like this can make existing psychological problems worse. Have you ever had any treatment or taken medication for a mental health problem?

For those with prior psychological problems, provide information about post-disaster reaction information about coping, information about social support, link with appropriate services, a follow-up meeting.

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Specific youth, adult, and family concerns over developmental impact

Interference with anticipated developmental activities and opportunities resulting from disas
post-disaster circumstances may cause distress and concern.

Information about this may be elicited with questions like:

Adult/ Caregiver	Were there any special things or events (birthday, graduation, beginning of the school year, vacation) coming up that were disrupted by the hurricane?

For those with developmental concerns, provide information about coping and link with appr
services.

It is also useful to ask a general open-ended question to make sure that you have not misse
important information.

Adult/ Caregiver/ Child	Is there anything else we have not talked about that is important for me to know?

The Psychological First Aid provider will need to use judgment about how to gather this infor
how much information to gather, and to what extent to ask questions, while remaining sensi
needs of the person. If the survivor identifies multiple concerns, summarize these and help
which issue is most pressing.

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5. Practical Assistance

Goal: To offer practical help to the survivor in addressing immediate needs and co

Assisting the survivor with current or anticipated problems is a central component of Psycho
First Aid. Ongoing adversities and continuing problems resulting from a disaster can add sig
to the stress level of the survivor, distract from self-care, and help maintain distress reaction
survivors may welcome a pragmatic focus on a current problem that is uppermost in their m
it is important to help them with problem-solving in regard to important problems.

Discussion of immediate needs occurs throughout a Psychological First Aid contact, and as m
possible, you should help the affected individual address those needs. Assistance may be h
because problem-solving may be more difficult for the survivor under conditions of stress an
adversity.

Identify the Most Immediate Need(s)

If several needs or current concerns have been mentioned by the survivor, it will be necessa
on them one at a time. For some needs there will be immediate solutions (e.g., getting som
eat, phoning a family member to reassure them that the survivor is OK). It will not be possib
rapidly solve other needs (e.g., locating a lost loved one, returning to previous routines, secu
insurance for lost property, acquiring caregiving services for family members), but it may be
to take concrete action steps that address the problem (e.g., completing a missing persons r
insurance form, applying for caregiving services).

As you collaborate with the survivor, help him or her to select issues requiring immediate he
example you might say:

Adult/ Caregiver	"I understand from what you're telling me, Mrs. Williams, that your main goal right now is to find your husband and make sure he's okay. Not knowing that he's safe and not being able to talk to him is very upsetting. We need to focus on helping you get in contact with him. In order to do that, let's make a plan on how to go about getting this information.

Clarify the Need

Talk with the survivor to specify the problem. If the problem is understood and clarified, it w
easier to identify practical steps that can be taken to address it.

Discuss an Action Plan

Discuss what can be done to address the individual's need or concern. The survivor may inc
he or she would like to be done, or you can offer a suggestion. Knowing what services are a
ahead of time will ensure that appropriate assistance can be provided about services related
obtaining food, clothing, shelter, medical, mental health, spiritual care services, financial ass
help in determining the location of missing family members or friends, and volunteer opport
those who feel a need to contribute to relief efforts. Inform survivors about what they can r
expect in terms of potential resources and support, qualification criteria, and application pro

Act to Address the Need

Follow through in making an active response. For example, help the person make contact or
appointment with a needed service, or assist them in completing paperwork.

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6. Connection with Social Supports

Goal: To help establish brief or ongoing contacts with primary support persons or of support, including family members, friends, and community helping resources.

Enhance Access to Primary Support Persons (Family and Significant Others)

An immediate concern for most affected persons is being able to communicate with individu whom they have a primary relationship (e.g., spouse/partner, children, parents, other family close friends, clergy). Social support can play a strong role in recovery from trauma. Theref important Psychological First Aid objective is to take practical steps to enable the person to contact (in person, by phone, by e-mail) with individuals for whom the person feels the grea concern (e.g., a child or frail elderly parent from whom the person has been separated) or th need to be with right now at that moment.

Encourage Use of Immediately Available Support Persons

If individuals are disconnected from their social support network, encourage them to make u immediately available sources of social support (i.e., yourself, other relief workers, other affe persons), while being respectful of individual preferences. For example, it can help to offer a reading materials (e.g., magazines, fact sheets) and discuss the material with them. When close proximity to each other, ask them, as a group, if they have questions or requests with can help. These group discussions can help provide a starting point for further conversations encourage social connectedness.

It can be helpful to bring similar-age children together in a shared activity - as long as they a separated from their adult caregivers. Providing art materials, coloring books, or building m can help younger children engage in soothing, familiar activities. Older children and adolesc be helpful in encouraging the younger children to participate. Children may have suggestion to sing or classroom games that they have played at school during recess. Several activities done with only paper and a pencil:

- Tic-tac-toe
- Folding “fortune tellers”
- Air hockey: wad up a piece of paper and have children try to blow it across the table into the other teams goal (Bonus: can be used to practice deep breathing exercises)
- Group drawing: have children sit in a circle, the first child begins a drawing. After 10 seconds, that child passes the drawing to the child on their right. Continue until everyone has added to the drawing. Then show the group the final picture. Suggest th the children draw something positive (not pictures of the disaster), something that promotes a better sense of protection and safety.
- Scribble game: pair up youth, one person makes a scribble on the paper, their partner has to add to the scribble to turn it into something

Discuss Support-Seeking and Giving

You can help survivors understand the value of social support, and how to be supportive to o instance, you can share that experts recommend that connection with others is an importan recovery from a disaster. Let them know that there are differences between normal stress an stress, which can cause people to want to avoid traumatic memories, or feel flooded by the Let them know that, following trauma, some people choose not to talk about traumatic expe all, or not until a later time when they feel secure enough re-visit the experience. And when feels comfortable talking, they may need to discuss the event on numerous occasions. Spen with people one feels close to and accepted by, without having to talk, can feel good. For ex your message might be:

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Adult/ Caregiver	“When you’re able to leave the Assistance Center you may just want to be with the people you feel close to. You may find that talking some about what each of you has been through can be helpful. You can decide when and what to talk about. You don’t have to talk about everything that occurred; only what you choose to share with each person. It’s good not to rush the talking, but also no to wait if it would help you or them to talk.”
Adolescent	“When something really upsetting like this happens, even if you don’t feel like talking, be sure to ask for what you need. Also, you might find that you will feel better if you try to help other people.”
Child	“You are doing a great job of letting grown-ups know what you need. It is important to keep letting people know how they can help you.” “You’re doing some great things to help the grown-ups too, like keeping an eye on your little brother and talking with these other kids who are scared.” “The more help you get, the more you can make things better. Even grown-ups need help at times like this.”

As a helper, you can model positive supportive responses, such as:

Reflective comments:
"It sounds like…"
"From what you're saying, I can see how you would be…."
"It sounds like you're saying…."
"You seem really…."

Make sure your reflections are correct by using sentences like:
“Tell me if I’m wrong … it sounds like you …”
“Am I right when I say that you …”

Supportive comments
"No wonder you feel…”
"It sounds really hard…"
"It sounds like you're being hard on yourself…"
"It is such a tough thing to go through something like this."
"I'm really sorry this is such a tough time for you."
"We can talk more tomorrow if you'd like…"

Empowering Comments and Questions:
"What have you done in the past to make yourself better when things got difficult?"
"Are there any things that you think would help you to feel better?"
"I have an information sheet with some ideas about how to deal with difficult situation
there is an idea or two here that might be helpful for you…."
"People can be very different in what helps them to feel better. When things get diffic
me, it helped me to….. Would something like that work for you?"

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If appropriate, distribute handouts such as those provided in ***Appendix E.*** These handouts for adults and older adolescents. Discuss the following points:

If an individual is reluctant to seek support, there may be many reasons, including:

- Not knowing what they need (an perhaps feeling that they should know)
- Feeling embarrassed or weak because of needing help
- Feeling guilty about receiving help when other are in greater need
- Not knowing where to turn for help when everyone else also needs help
- Worrying that they will be a burden or depress others
- Fearing that they will get so upset that they'll lose control
- Doubting that such support will be helpful
- Preferring to avoiding thinking or having feeling about what happened
- Telling themselves that "no one can understand what I'm going through"
- Having tried to get help and felt that help wasn't there (feeling let down or betrayed)
- Fearing the people they ask will be angry at them or make them feel guilty for needing

When Support is Not Working:

You may need to inform individuals that if someone they care about is showing *extreme soci isolation or withdrawal*, they can help the person choose specific ways to be involved with o people in a way that they feel will be helpful. A friend or loved one may need to also know t are other people who can listen if more help is needed (i.e., primary care doctor, chaplain, s group, or counselor). Let them know that positive social support, in any way that is accepta them, is one of the most crucial factors in recovery from a disaster. They can enlist help fro their social circle so that they all take part in supporting the person. They can also encourag friend/loved one to get involved in a support group with others who have had similar experie accompany them in seeking professional help.

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7. Information on Coping

Goal: To provide information (about stress reactions and coping) to reduce distres adaptive functioning.

Disasters can be disorienting, confusing, and overwhelming. Various types of information ca re-orient children and adults to their situation. Such information includes:

- What is currently known about the unfolding event
- What is being done to assist them
- What services are available
- Post-disaster reactions and how to manage them
- Self-care, family care, and coping

Psychological First Aid providers should use judgment as to when to present information, and the type of information that is most pertinent and useful. The most useful information provid assistance in addressing immediate needs, reducing distress, addressing current concerns, a supporting positive coping efforts.

Provide Basic Information about Stress Reactions

If appropriate, it may be useful to briefly discuss common stress reactions being experienced survivor. Stress reactions may be alarming for survivors. Some will be frightened or otherw distressed by their own responses to an event; some may view their reactions in negative an distressing ways (e.g., my reactions mean "There's something wrong with me," or "I'm weak Therefore, individuals may benefit from explanations about reactions that they are experienc understanding that these reactions are normal and expectable. Some important considerati process of educating survivors about their reactions include:

- Build any discussion around their individual reactions.
- Take care to avoid pathologizing survivor responses; don't use terms like "symptoms."
- Distribute the appended handouts consistent with content areas. This will allow a way survivors to review these materials after your meeting. Remember that stress may int with the ability to understand and remember information.

Provider Alert: While it may be helpful to describe common stress reactions and note tha reactions are common but often diminish over time, it is also important to avoid providin "blanket" reassurance that stress reactions will disappear. This may set up unrealistic expectations, resulting in negative views of self if reactions persist.

Review Common Psychological Reactions to Traumatic Experiences and Losses

Especially for individuals who have had significant exposure to trauma and have sustained significant losses, provide basic psycho-education about common distress reactions. The Psychological First Aid provider can review these, again emphasizing that such reactions are understandable and expectable. Inform survivors that if these reactions continue to interfere with their ability to function adequately for over a month, psychological services should be considered.

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Many individuals who have had traumatic experiences suffer from ongoing reactions that are distressing and can lead to difficulties in daily life.

Provider Alert: The following basic information is presented as an overview for the Psychological First Aid provider so that issues arising from survivors' past experiences and post-disaster reactions can be selectively discussed as appropriate.

There are three types of posttraumatic stress reactions:

Intrusive reactions are ways in which the traumatic experience comes back to mind These reactions include distressing thoughts or images of the event (e.g., picturing what one saw), or dreams about what happened. Among children, bad dreams can occur that may no specifically about the disaster. Intrusive reactions also include upsetting emotional or physi reactions to reminders of the experience. Some people may act like one of their worst experiences is happening all over again. This is called "a flashback."

Avoidance and withdrawal reactions are ways people use to keep away from, or p against, intrusive reactions. These reactions include efforts to avoid talking, thinking and having feelings about the traumatic event, and to avoid any reminders of the event, includin places and people connected to what happened. Emotions can become restricted, even nu to protect against distress. Feelings of detachment and estrangement from others may lead social withdrawal. There may be a loss of interest in usually pleasurable activities.

Physical arousal reactions are physical changes that make the body react as if dan still present. These reactions include constantly being "on the lookout" for danger, startling easily or being jumpy, irritability, or experiencing outbursts of anger, difficulty falling or staying asleep, and difficulty concentrating or paying attention.

It is also useful to discuss the role of trauma reminders, loss reminders, and hardships in co to distress.

Trauma Reminders can be sights, sounds, places, smells, specific people, times of th situations, or even feelings, like being afraid or anxious. Trauma reminders can evoke upsett thoughts and feelings about what happened. Examples include the sound of wind, rain, heli screaming or shouting, and specific people who were present at the time. Reminders are rel specific type of event, such as hurricane, earthquake, flood, tornado or fire. Over time, avoi reminders can make it hard for people to do what they normally do or need to do.

Loss Reminders can also be sights, sounds, places, smells, specific people, the time situations, or feelings. Loss reminders bring to mind the absence of a loved one. Missing the can bring up strong feelings, like sadness, feeling nervous, feeling uncertain about what life without them, feeling angry, feeling alone or abandoned, or feeling hopeless. Examples inclu a picture of a lost loved one, or seeing their belongings, like their clothes. Loss reminders ca to avoiding things that people want to do or need to do.

Change Reminders can be things (people, places, things, activities, or hardships) tha us of how our lives have changed from what they used to be as the result of a disaster. This something as simple as waking up in a different bed in the morning, or going to a different s being in a different place. Even nice tings can remind us of how things have changed, and m miss what we had before.

Hardships often follow in the wake of disasters, and can make it more difficult to rec Hardships place additional strains on children and families, and can contribute to feelings of depression, irritability, uncertainty, and mental and physical exhaustion. Examples of hardsh

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include: loss of home or possessions, lack of money, shortages of food or water, separations friends and family, medical or physical health problems, the process of obtaining compensat losses, school closures, being moved to a new area, and lack of fun things for children to do.

Other kinds of reactions include grief reactions, depression and physical reactions.

Grief Reactions will be prevalent among those who survived the disaster but have suffered many types of losses – including loss of loved ones, home, possessions, pets, schoo and community. Loss may lead to feelings of sadness and anger, guilt or regret over the loss missing or longing for the deceased, and dreams of seeing the person again. These grief reactions are normal, vary from person to person, and can last for many years after the loss. There is no single "correct" course of grieving. Importantly, personal, family, religious and cultural factors affect the course of grief. Although grief reactions may be painful to experience, especially at first, they are healthy reactions and reflect the ongoing significanc the loss. Over time, grief reactions tend to include more pleasant thoughts and activities, su as positive reminiscing or finding positive ways to memorialize or remember a loved one.

Traumatic Grief occurs when children and adults have suffered the traumatic loss of loved one, and often makes grieving more difficult. In traumatic death, there is a tendency f the mind stay focused on the circumstances of the death, including preoccupations with how the loss could have been prevented, what the last moments were like, and issues of accountability. Traumatic grief reactions include intrusive, disturbing images of the manner death that interfere with positive remembering and reminiscing, delay in the onset of health grief reactions, retreat from close relationships with family and friends, and avoidance of usu activities because they are reminders of the traumatic loss. Traumatic grief changes t course of mourning, putting individuals on a different time course than may be expected by other family members. Often, traumatic grief reactions can clash with the timing of religious rituals and other cultural expressions of mourning.

Depression can be an additional major concern. Depression is associated with prolonged grief reactions and strongly related to the accumulation of post-disaster adversitie Reactions include: persistent depressed or irritable mood; loss of appetite; sleep disturbance often early morning awakening; greatly diminished interest or pleasure in life activities; fatig or loss of energy; feelings of worthlessness or guilt; feelings of hopelessness; and sometime thoughts about suicide. Demoralization is a common response to unfulfilled expectations ab improvement in post-disaster adversities, and resignation to adverse changes in life circumstances.

Physical Reactions may be commonly experienced, even in the absence of any underlying physical injury or illness. These reactions include: headaches; dizziness; stomachaches; mus aches; rapid heart beating; tightness in the chest; loss of appetite; and bowel problems.

These handouts may be useful and can be found in **Appendix E**.

- ***Handout: When Terrible Things Happen*** describes common reactions and positive/negative coping
- ***Handouts: Tips for Helping Preschool Age children; Tips for Helping School A Children; and Tips for Helping Adolescents*** are intended to be given to parents a caregivers. These describe common reactions for children in different age groups (6 years old and younger, 6-12 years old, adolescents), and give suggestions on ways for parents/caregivers to help their children adjust.

Provide Basic Information on Ways of Coping

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It may also be appropriate and helpful to discuss various ways of coping.

Adaptive coping actions are those that help to reduce anxiety, lessen other distressing re
improve the situation. In general, coping methods that are likely to be helpful include:

- Talking to another person for support
- Getting adequate rest, diet, exercise
- Engaging in positive distracting activities (sports, hobbies, reading)
- Trying to maintain a normal schedule to the extent possible
- Scheduling pleasant activities
- Eating healthy meals
- Taking breaks
- Spending time with others
- Participating in a support group
- Using relaxation methods
- Using calming self talk
- Exercising in moderation
- Seeking counseling
- Keeping a journal

Maladaptive coping actions tend to perpetuate problems. Such actions include:

- Using alcohol or drugs to cope
- Withdrawing from activities
- Withdrawing from family or friends
- Working too many hours
- Getting angry or violent
- Blaming others
- Overeating
- Watching too much TV or playing too many computer games
- Doing risky or dangerous things
- Not taking care of oneself (sleep, diet, exercise, etc.)

The aim of discussing positive and negative forms of coping is to:

- Help survivors consider coping options
- Identify and acknowledge their coping strengths
- Explore the negative consequences of maladaptive coping actions
- Encourage survivors to make conscious choices about how to cope
- Enhance a sense of control over coping and adjustment

As noted above, ***Handout*****: *When Terrible Things Happen*** reviews positive and negative
survivors in general. This handout can be found in **Appendix E**.

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Demonstrate Simple Relaxation Techniques

Breathing exercises help reduce feelings of over-arousal and physical tension. Simple exercis
can be taught in a brief period. Children and adolescents can use these techniques also, and
for parents to prompt their children (or vice versa) to use these techniques several times a d

Handout: Basic Relaxation Exercises can be provided to reinforce the use of relaxation t
found in **Appendix E**.

Adult/ Caregiver/ Adolescent	Inhale slowly (one-thousand one; one-thousand two; one-thousand three) through your nose and comfortably fill your lungs all the way down to your belly. Silently and gently say to yourself, "My body is filling with calm." Exhale slowly (one-thousand one, one-thousand two, one-thousand three) through you mouth and comfortably empty your lungs all the way down to your abdomen. Silently and gently say to yourself, "My body is releasing tension." Repeat five times slowly and comfortably.
Child	Let's practice a different way of breathing that can help calm our bodies down. Put one hand on your stomach, like this [demonstrate]. Okay, we are going to breathe in through our noses. When we breathe in, we are going to fill up with a lot of air and our stomachs are going to stick out like this [demonstrate]. Then, we will breathe out through our mouths. When we breathe out, our stomachs are going to suck in and up like this [demonstrate]. We are going to breathe in really slowly while I count to three. I'm also going to count to three while we breathe out really slowly. Let's try it together. Great job

Engaging ways to practice deep breathing:

- Blow bubbles with a bubble wand and dish soap
- Blow bubbles with chewing gum
- Blow paper wads or cotton balls across the table – make a game of it!

For Parents or Caregivers, Review Special Considerations for Children

For parents or caregivers, ***Handouts: Tips for Helping Preschool Children; Tips for He
Age Children; and Tips for Helping Adolescents*** provide specific information about age
reactions, and strategies for addressing these to assist in children's recovery. They address
years old and younger, children 6-12, and adolescents. These information sheets should be
parents or caretakers for their use over the next weeks and months. These handouts can be
Appendix E.

Establishing family routines *to the extent possible* after a disaster is important for family rec
is especially important to encourage parents and caregivers to try to maintain family routine
meal times, bedtime, wake time, reading time, and play time. This can be done in a shelter
transitional housing.

Encourage youth and family members to pay special attention to taking care of their *physica*
This includes getting enough sleep, proper nutrition (including fluid intake), proper exercise,
hygiene, and setting aside time for enjoyable activities.

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It is especially important to assist family members in developing a mutual understanding of different experiences, reactions and course of recovery, and to help develop a family plan fo communicating about these differences. For example, a provider might say:

Adult/ Caregiver	Often, due to differences in their experiences during and after a disaster, family members will have different reactions and different courses of recovery. These differences can be difficult for family members to deal with, and can lead to difficulties like not feeling understood, getting into arguments, or not supporting each other. For example, one family member may be more troubled by a trauma or loss reminder than other family members.

The Psychological First Aid provider should encourage family members to be understanding, and tolerant of differences in their reactions, and to talk about things that are bothering ther others will know when and how to support them. People can support and help each other in of ways, like listening and trying to understand, comforting with a hug, doing something tho like writing a note, or getting their mind off things by playing a game. Parents need to pay s attention to how their children may be troubled by reminders and hardships because they ca affect how their children appear and behave. For example, a child may look like he is having tantrum when actually he has been reminded of a friend who was hurt or killed.

Assist with Developmental Issues

Children, adolescents, adults and families go through stages of physical, emotional, cognitiv social development. The many stresses and adversities in the aftermath of a disaster may r interruptions, delays or reversals in developmental progression. The loss of developmental opportunities or achievements can be experienced as a major consequence resulting from th Developmental progression is often measured by milestones.

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Examples of Developmental Milestones	
Young Children	•becoming toilet trained •entering preschool •riding a tricycle
School Age Children	•learning to read and do arithmetic •being able to play by rules in a group of children •handling themselves safely in a widening scope of unsupervised time
Early Adolescents	•having friends of the opposite sex •pursuing organized extracurricular activities •striving for more independence and activities outside of the home
Older Adolescents	•learning to drive •getting a first job •dating •going to college
Adults	•starting or changing a job or career •getting engaged or married •having a child/having children leave home
Families	•buying a new home or moving •going through a separation or divorce •experiencing the death of a grandparent
All Ages (Developmental Events)	•graduations •birthdays •special events

In responding to needs and concerns after a disaster, even though attention will be paid to t
are immediate, children and families should also be given an opportunity to attend to the dis
impact on development. It can be useful to help children and families identify any of these i
asking directly.

Parent/ Caregiver	Are there any special events that the family was looking forward to? Was anyone looking forward to doing something important, like starting school, graduating from high school, or entering college?
Adult	Are there any goals you were working towards that this disaster has, or might, interfere with?
Child/ Adolescent	Were there things before the hurricane that you were looking forward to doing? Like a birthday, something fun at school, or going somewhere with a friend.

The Psychological First Aid provider should try to increase appreciation of family members to
issues, so that they understand the challenge to each individual, as well as the whole family
alternative ways for family members to handle the interruption or delay. In helping to devel
to help with these concerns, consider whether:

•the event can be postponed to a later date
•the event can be relocated to a different place
•changes in expectations need to take place so that the family members are able to tolerate
postponement
•steps can be taken to put these changes in place

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Assist with Anger Management

In post-disaster situations, with stress and adversity, including difficulty sleeping, some indiv
may be irritable and have difficulty managing their anger. When appropriate, the Psycholog
Aid provider can discuss the following anger management issues.

- Discuss how the anger is affecting the person's life (e.g., relationship with family membe
  friends, including effects on parenting).
- Normalize the experience of anger, and discuss specifically how anger could increase co
  push others away, or lead to violence.
- Ask the person to identify changes he/she would like to make.

Some anger management skills that you can suggest include:

- Taking a "time out" or "cool down"
- Reminding yourself that being angry will not help you achieve what you want, and may h
  important relationships.
- Increasing exercise or other tension-reducing activities
- Talking to a friend about what's angering you
- Remembering that when you are feeling particularly angry or irritable, have another fam
  member temporarily supervise your children's activities

If anger appears uncontrollable, or leads to violence, seek immediate medical attention, and
security.

Address Highly Negative Emotions (e.g., guilt and shame)

In the aftermath of disasters, survivors may think about what caused the event, how they re
what the future holds. Some of these beliefs may add to their distress, especially attributing
blame to themselves. The Psychological First Aid provider should listen for such negative be
help survivors to identify alternatives to the negative beliefs that are causing distress. Some
that can facilitate this process are:

- How else could you look at the situation that would be less upsetting and more helpfu
  What's another way of thinking about this?
- How might you respond if a good friend was talking to himself/herself like this? What
  you say to them? Can you say the same things to yourself?

It may be helpful for the individual to hear that just because he or she *thinks* she is at fault d
mean that this is true. If the individual is receptive, you can offer some alternative ways of l
the situation. An important role for the Psychological First Aid provider in this effort is to atte
clarify misunderstandings, rumors, and distortions that exacerbate distress, unwarranted gu
shame.

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Help with Sleep Problems

Sleep difficulties are very common following a disaster or other trauma. Ask questions to as individual's sleep routines and sleep-related habits. Problem-solve ways of improving sleep, including:

- Go to sleep at the same time and get up at the same time each day
- Reduce alcohol consumption: alcohol disrupts sleep
- Eliminate consumption of caffeinated beverages (e.g., coffee, soft drinks) in the afternoo evening
- Increase regular exercise, though not too close to bedtime
- Relax before bedtime by doing something calming, like listening to soothing music, or pr
- Limit daytime naps to 15 minutes and not napping later than 4pm
- Discuss that worry over immediate concerns and exposure to daily reminders can make difficult to sleep, and that being able to discuss these and get support from others can im sleep over time.

Address Alcohol and Substance Use

When use of alcohol and other substances is a concern:

- Educate the individual regarding the tendency for many people who experience stress re drink or use medications or drugs to reduce their bad feelings.
- Ask the individual to identify what they see as the "pro's and con's" of using alcohol or d cope.
- Discuss and mutually agree on abstinence or a safe pattern of use.
- Discuss anticipated difficulties in making change.
- If appropriate and acceptable to the person, make a referral for substance abuse counse
- If the individual has previously received treatment for substance abuse, encourage him once again seek treatment to get through the next few weeks and months.

The ***Handout: Alcohol and Drug Use after Disasters*** gives an overview of this informati intended for adults and older adolescents who indicate concerns in this area. This handout found in **Appendix E**.

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8. Linkage with Collaborative Services

Goal: To in form and link individuals with available services needed at the time or

Provide Direct Link to Additional Needed Services

Providing information should be accompanied by a discussion about which of the survivor's n current concerns require additional information or services. If the survivor is interested in ac services, do what is necessary to insure effective linkage with those services (e.g., walk the over to an agency representative who can provide a service; set up a meeting with a commu representative who may provide appropriate referrals).

When making a referral:

- First summarize your discussion with the person about their needs and concerns
- Check for accuracy of your summary
- Describe the option of referral, including how this may help and what will take place if individual goes for further help
- Ask about reaction to suggestion of referral
- Give written referral information, or if possible, make an appointment then and there

Promote Continuity in Helping Relationships

A secondary, but important concern for many affected persons is being able to keep in conta helpers and other persons whom they feel have been or could be helpful as they continue to the immediate situation.

In most cases, continuing contact between affected survivors and you will **not** be possible b affected persons will leave triage sites or family assistance centers and go to other sites for services. However, contacts made during the acute aftermath of disasters can lead to a sen abandonment or rejection if the Psychological First Aid provider seems to just "vanish." The Psychological First Aid should include the use of strategies for creating a psychological sense continuity of care, such as:

- Give the name(s) and contact information for the local public health and public mental service providers in the community. There may also be other local providers or recogn agencies who have volunteered to provide post-disaster follow up services for the com (Be wary of referring to unknown volunteer providers.) – Such information may not be for several hours or days, but once available, it can be considerably helpful to disaster survivors.
- Introduce the survivor to other mental health, health care, family service, or relief wor that they know several helpers by name rather than only you.

Sometimes, survivors feel as if they are meeting a never-ending succession of helpers, and t have to go on explaining their situation and telling their story to each one in turn. To the ext possible, this should be minimized. If you are leaving a response site, it is important to let th know this and to ensure a direct "hand-off" to another provider, and if possible, one who will position to maintain an ongoing helping relationship with the person. Orient the new provide he or she needs to know about the person, and provide an introduction if at all possible.

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Adult/ Caregiver/ Adolescent	“I’ll be here tomorrow and for the rest of the week and will look for you – if you’re here or want to stop by, would you look for me and let me know how you and your family/friends are doing?”
Child	“Thanks for staying with your brother, I know that’s a big help to your parents while they’re figuring out how to make sure you’re all safe. I’ll keep checking on you while I’m here, and if you have a chance and would like to make a drawing that I could keep to remember you, I’d really like that. I’ll try to say goodbye if I have to go.”

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Appendix A: MRC Service Delivery Sites and Setti

Service Site Challenges in Delivering Psychological First Aid

Medical Reserve Corps members can face many challenges in providing PFA to disaster surv relief personnel. These challenges are often related to the specific disaster characteristics (vs. human caused, size, location) and those of the individuals involved (e.g. populations of s consideration-elders, physically challenged, youth, disadvantaged groups, individuals with p psychiatric illness). Of considerable challenge can be the settings in which medical reserve members are assigned. The following information will be helpful in anticipating and understa unique challenges of some disaster related service sites.

General Population Shelters

When it is determined that a community or area of the community must be evacuated becau dangerous or threatening conditions, *General Population Shelters* are opened for the tempor housing of individuals. General Population Shelters are usually located in schools, communit recreation centers, or in other large facilities. Shelters usually have limited space for people and eat as well as an area for meals to be served. Typical challenges include establishing sh (e.g. lights out, regulated use of showers when in limited supply, feeding hours), addressing cultural and ethnic issues that arise when bringing diverse populations together, managing p health issues (e.g. sanitation, medication dispensing, isolating the sick) and resolving the ine disputes that arise between shelter residents and each other or between shelter residents a

Respite Centers

Respite Centers are locations where first responders can rest and obtain food and clothing a basic support services. The decision to open a Respite Center is usually determined if there that prolonged rescue and recovery efforts are necessary. Respite Centers are usually locate proximity to the direct impact of a disaster. Typical challenges include limited interaction wi responders given the usual frenetic pace of the response in the early aftermath of disaster, t on behalf of the responders to continue working, especially if the response is still in the 'resc and in many cases, the responders need to emotionally 'distance' themselves can create sig barriers for MRC personnel in providing PFA activities.

Hospital-Hospital Emergency Room Settings

During a mass casualty incident, survivors that are triaged on site and listed as "immediate" brought to a hospital. In addition, many others will self transport to the hospital wanting to the Emergency Room. This is likely to create a surge on medical resource capacity. Psychol causalities, as well as medical causalities, may arrive in large numbers, as well as those who combined psychological and physical symptoms.

One important goal is to facilitate the treatment of injured survivors by removing individuals not require immediate medical care from the patient flow. However, increased physical sym have frequently been reported after disasters, particularly among those who witness injury a and those who may have had toxic exposure to a chemical or biological attack. As a result, diagnosis may at times be difficult, since signs and symptoms may be nonspecific and/or sta change over time. News or rumors of such an attack may generate thousands who fear they exposed, and rapidly overwhelm the system. Along with a system of triage, hospitals may s "support center" where PFA providers can refer those in need to a spectrum of psychologica behavioral and pharmacological interventions.

Depending on the incident or numbers, the Emergency Room may experience a "shut down. awaiting bed availability, those who are in need of medical care or who have been decontam be placed in holding areas for observation. These survivors will benefit from Psychological F

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If survivors are admitted to the hospital, the integration of medical care and PFA for medical-
casualties is imperative. In addition, family members, friends and co-workers will come to th
hospital, some of them searching for missing friends and loved ones, others awaiting news o
progress. These individuals may also benefit from PFA.

Service Centers

Service Centers may be opened by a local or federal governmental agency or by disaster rel
organizations to meet the initial needs of disaster survivors. These centers typically offer ass
with locating temporary housing or providing for the immediate personal needs of disaster s
such as food, clothing, and clean-up materials. Depending on the size and magnitude of the
MRC personnel may encounter large numbers of survivors seeking services, anger and frustr
expressed by survivors who perceive assistance is not reaching them in a timely or efficient
and aggressive or hoarding behaviors in those survivors who perceive inadequate supplies t
around.

Emergency Operation Center

On-going mental health support services may also be requested at the county's *Emergency*
Center (EOC). In the aftermath of a large-scale disaster, the EOC is a chaotic and stressful
environment as county, and other organizational disaster planners and managers are prepar
disaster relief response.

Community Outreach Teams

Community Outreach Teams are usually established in the event of disasters that affect a la
geographic area and/or a significant percentage of the population. These teams are often ne
avoid long lines at Service Centers or when transportation services for the general populatio
limited. The teams usually represent two (2) or more individuals that can provide compreher
services to disaster survivors. For example, a disaster mental health or spiritual care profess
be teamed up with a representative from the American Red Cross who can provide assistanc
meeting the survivors' food, clothing, and shelter needs.

Emergency First Aid Stations

Emergency First Aid Stations provide basic medical services to disaster survivors as well as
who may suffer minor injuries in the rescue and recovery efforts following a disaster. They a
located in close proximity to the direct impact of a disaster. In the event of a disaster resulti
casualties, makeshift emergency first aid stations may be set up in close proximity of your h
facility in an effort to relieve the burden of emergency room services and ensure that such h
care is available to the seriously injured.

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Phone Banks and Hotlines

Communities and healthcare systems may wish to set up a *Phone Bank* to address and respo
numerous calls with questions that typically arise after a disaster. These Phone Banks are lik
overwhelmed in the first few hours or days with many questions or concerns regarding such
locating missing or injured family members or healthcare concerns or issues. Community ho
may encounter similar questions and address additional information such as the availability
locations, mass food distribution sites and other disaster relief services.

Points of Dispensing (POD) Centers

PODs might be established by local, state, or federal public health agencies in the event of a
health emergency. These centers may be established to provide mass distribution of medica
vaccinations in an effort to prevent or mitigate the spread of any communicable disease or c
health risk. Healthcare facilities may open PODs with the goal of vaccinating or distributing
medications to its own personnel or to reduce the burden on the community POD sites.

Volunteer Staging Area

In the event of large-scale disasters requiring significant volunteer resources, a *Volunteer St*
may be established by a particular disaster relief agency, by a local, state, or federal govern
agency, or by a healthcare system for its own personnel. Typically, activities in the Volunteer
Area include the registering of volunteers for duty and the credentialing of those involved in
requiring specific skill sets such as mental health or health services. It is important for you t
understand that you will be assigned to a service site where you are needed most. While you
a preference for one site over another, the response needs will require you to be flexible. Su
relief personnel are equally important in our response to providing mental health and spiritu

Family Reception Centers (FRC)

Family Reception Centers are typically opened in the immediate aftermath of a disaster invo
casualties or fatalities. There is a common recognition that after such disasters, individuals r
trying to locate family or other loved ones specifically involved in the disaster or estranged c
evacuation process. Often these are temporary holding sites until a more structured and ope
Family Assistance Center can be opened. Family Reception Centers may be established in cl
proximity to the immediate disaster scene where individuals arrive in search of family and o
ones involved in the incident or in healthcare facilities where the injured have been transpor

Family Assistance Centers (FAC)

Family Assistance Centers are commonly opened in the event of a disaster involving mass c
fatalities. These centers usually offer a range of services in an effort to meet the needs of in
under these circumstances. Mental health services, spiritual care, catering, and crime victim
as well as the services of law enforcement, the medical examiner, disaster relief agencies, a
local, state, and federal agencies are also offered on site. Family Assistance Centers are usu
away from the immediate disaster site, though it is important to note that many times, fami
will request visits to the affected site or memorial services will be planned, and thus the FAC
close enough to facilitate those activities.

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First Responder and Disaster Relief Personnel Units

Individuals belonging to First Responder units[3] or other disaster relief response groups may experience
range of reactions as a result of in the aftermath of their disaster response. These reactions
typically result in severe psychological dysfunction and rarely require extensive mental healt
intervention. In fact, most reactions will cause minor distress for the individual and will remi
relatively short period of time. A small minority of workers will require more significant ment
intervention for their reactions, typically administered later in the individual's recovery.

For many first responder units, a mandated (or strongly encouraged or entirely voluntary) gr
intervention in the aftermath of a disaster or other critical incident has become part of their
disaster routine. Often these group interventions, which focus on the goal of mitigating futur
psychological distress in those exposed to such events, follow a prescribed, structured proce
as a demobilization, defusing, or a critical incident stress debriefing. On occasion MRC units
members, are invited to facilitate these structured group interventions or act as co-facilitato
'mental health consultants' when internal or external peer group facilitators are used.

Given the MRC's position statement on psychological debriefing and similarly structured inte
that include the detailed recounting of one's disaster experience (see Appendix B), special c
consideration must be given to these requests for assistance.

All efforts should first be made to support the provision of Psychological First Aid individually
members. If a group process is advised, consider using a psychoeducational format. That is,
group participants with information regarding the common or anticipated stress reactions ty
identified in responder groups following disaster and specific methods for engaging stress re
self-care activities. It is also advisable to provide participants with information that assists t
identifying reactions that may require or necessitate additional mental health assistance and
mental health resources available to provide such services.

[3] While traditionally thought of as police, fire, and EMS responders, other individuals or groups may be consider
include: search and rescue teams, salvage teams, DMORT and medical examiner's staff, DNA and forensic spec
media personnel, spiritual care providers, hospital personnel, hotel food service and janitorial staff, CERT volun
transportation crews.

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Appendix B: Position Statement and Guidance fo Units on Psychological Debriefing

Medical Reserve Corps
National Disaster Mental Health Work Group
April 2006

The National MRC Mental Health Work Group has developed this position statement on the u ***psychological debriefing*** as an early mental health intervention in the aftermath of disast position statement is intended to assist individual MRC units and the response community in development of policy and practice as they relate to the provision of acute mental health se disaster survivors and MRC personnel.

Recommendation:
Because of the possibility of psychological harm to individual participants, 'Psychological Debriefing' should NOT be a part of the standard mental health response to crisis and disas situations.

Mandatory or 'required' psychological interventions should not be universally applied to sur or responders following disaster.

Rationale

Major controversy has evolved over the use of psychological debriefing as an early intervent strategy for individuals or responders exposed to disasters or other major traumatic events. Additionally, considerable ambiguity surrounding the term 'debriefing' and inconsistencies in debriefings are conducted have added to this controversy and confusion in the field.

Mental health experts, professional organizations and a number of federal and state task for consistently advised and recommended that psychological debriefing not be utilized as a sta intervention technique.

This has come about, in part, due to research that suggests:

There is no convincing evidence that psychological debriefing prevents PTSD related mental disorders.[4]

Some individuals may be harmed by debriefing, with the "systemic ventilatio the potentially most harmful phase.[5]

An individual sense of control or mastery is important in (one's) recovery.[6]

[4] Kenardy JA, Webster RA, Lewin TJ, Carr VJ, Hazell PL, Carter GL. Stress debriefing and patterns of recovery follo natural disaster. *J Trauma Stress* 1996; 9: 37-4.
[5] Ørner RJ, Kent AT, Pfefferbaum BJ, Raphael B, and Watson PJ. (2006). The Context of Providing Immediate Post Intervention. In: EC Ritchie, PJ Watson, & MJ Friedman (eds.), *Interventions Following Mass Violence and Disaste* New York: The Guilford Press.
[6] Watson P, Ritchie EC, Demer J, Bartone P, Pfferbaum BJ. (2006). Improving Resilience Trajectories Following Ma Violence and Disaster. In: EC Ritchie, PJ Watson, & MJ Friedman (eds.), *Interventions Following Mass Violence an Disasters*. New York: The Guilford Press.

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Background

The Medical Reserve Corps (MRC), as one of the newest organizations in the disaster respon community, has evolved rapidly since its creation in 2002, by the Office of the Surgeon Gen United States Public Health Service (USPHS). With more than 400 individual units and over members, MRCs have become a prominent vehicle for pre-registering, credentialing and trai health (and mental health) professional volunteers in disaster response.

As the MRC program evolved, it became evident that individual MRC units were seeking assi interpreting best practices and developing response guidelines across a host of operational response, the MRC National Program Director, Commander Robert Tosatto, USPHS, initiated s work groups to help identify some common guidelines and policy objectives for MRC units to consider, while at the same time respecting the local autonomy of each individual unit. One focus areas is Disaster Mental Health.

The MRC Mental Health Work Group was convened to provide guidance to local MRC units specifically in the areas of disaster mental health where to date, no standard approach exist response strategies remain unclear. Upon examination of the field the MRC Mental Health W Group identified a host of issues pertinent to MRC policy and field operations that need to be addressed. These issues include:

- establishing professional core competencies to insure a consistent, well-trained workfo
- identifying existing training curricula or developing new curricula that embrace these competencies;
- identifying and resolving gaps in service delivery;
- clarifying and resolving controversies related to the provision of MRC-related disaster m health interventions in the field.

While each of the above issues is critical to establishing a highly skilled volunteer workforce issue is the current controversy surrounding psychological debriefing.

Overview and Clarification of the Term Debriefing

Debriefing as a concept has evolved over the years into an ambiguous term. Even among e services and disaster operations personnel, there is *no uniform application* of the term. It is important to understand these different meanings to ensure that we are communicating the message and providing appropriate care to those exposed to traumatic events, including vic families and response personnel.

Operational debriefing is an organizational process and is *not* considered a psychological int An operational debriefing is typically implemented shortly after a major event or training exe review the process of the response and identify successes and failures of the activity.

The primary intent of *operational debriefing* is to gather information about an event for lead to convey important “lessons learned” to the participants. Operational debriefings also allow opportunity to problem-solve current response needs and identify potential sources of suppo response personnel. The operational debriefing process has been used extensively by milita civilian agencies for intelligence gathering and informational purposes, providing an evaluat quality improvement component to response activities and field operations.

“*Operational debriefing,* in first responder settings, **is not a psychological intervention** b collection of shared information (minus emotional processing), and may be helpful in allowin construction of a more coherent, shared narrative of the incident among those who have wo together or have a shared support system,”[7]

[7] Ørner RJ, Kent AT, Pfefferbaum BJ, Raphael B, and Watson PJ. (2006). The Context of Providing Immediate Post Intervention. In: EC Ritchie, PJ Watson, & MJ Friedman (eds.), *Interventions Following Mass Violence and Disaste*

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Psychological Debriefing is a technique of early intervention employed after a traumatic eve
intent of helping an individual process the event and its linked emotional content. One of th
commonly used *psychological debriefing* techniques is Critical Incident Stress Debriefing (CI
CISD, a component of Critical Incident Stress Management (CISM), has been widely embrace
first responder populations (police, fire, and EMS) as a mechanism for supporting personnel
aftermath of potentially psychologically distressing events.

In 2001 the National Institute of Mental Health (NIMH) convened a group of disaster mental
experts to explore the efficacy of early psychological interventions and attempt to clarify the
controversy surrounding *psychological debriefing*. These consensus findings were also inter
provide some guidance for the provision of mental health intervention in the early aftermath
violence and other disasters. The group's findings in relation to debriefing were as follows:

> *There is **some** Level 1 evidence (Level 1 evidence is considered the most reliable type
> evidence in most cases) suggesting that early intervention in the form of **a single on
> **one recital of events and expression of emotions** evoked by a trau
> advocated in **some forms** of psychological debriefing) **does not consistently reduc
> later developing PTSD or related adjustment difficulties.*
>
> *Some survivors (e.g., those with high arousal) may be put **at heightened risk for ad
> **outcomes** as a result of such early interventions*[8]

Over the past five years mental health experts have continued to review the literature on th
psychological debriefing and have found similar conclusions. Ørner, Kent, Pfefferbaum, Raph
Watson, reaffirmed the NIMH psychological debriefing findings and stated:

> ***There is currently no empirical evidence to support any intervent
> components of trauma remembrance and emotional processing in the early
> following mass violence….***
>
> ***The most positive results from early interventions are usually for those that
> community support and address survivors' human affiliation needs
> survivors establish contact with relatives) rather than interventions
> individual psychological reactions.***[9]

Summary and Recommendations

It is becoming clear across all emergency and disaster mental health disciplines--there is no
fits all" approach to addressing and responding to the mental health consequences of disast
critical that those responsible for community planning and response begin to develop an inte
flexible mental health response plan that is guided by the evidence-- when evidence exists.

Because the findings (cited previously in this Position Statement and those included in the e
this appendix) suggest that *psychological debriefing* does not prevent trauma-related menta
problems and puts some exposed persons at risk of adverse outcomes, it is the recommenda

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New York: The Guilford Press.

[8] National Institute of Mental Health (2002). *Mental Health and Mass Violence: Evidence-Based Early Psychologi
Intervention for Victims/Survivors of Mass Violence. A Workshop to Reach Consensus on Best Practices*. NIH Pu
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work group that *psychological debriefing*, or *techniques that include trauma remembrance a* *emotional processing*, should *NOT* be part of the routine MRC mental health response to disa other crisis situations.

The disaster mental health response begins long before a disaster occurs and should be an i of the overall community disaster plan. Ideally, plans will include an early focus on communi education, discussions of realistic expectations following events, risk communication metho content, triage and screening-both on the scene and in hospitals, as well as post-event avail psychoeducational informaiton, community resilience activities, individual and group crisis c and more definitive mental health treatment, when indicated for those more severely affecte disaster.

Further, the responsibility for providing supportive interventions during disaster can and sho beyond just the mental health professional alone. Educating and training all disaster respon concepts of Psychological First Aid (PFA) or other supportive problem- solving and comfort ca activities, strengthens the overall disaster response and ensures that those individuals impa disaster and its aftermath have a greater opportunity to have their practical and psychosoci addressed early on, and as a result, potentially minimize long- term psychological consequer

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MRC Psychological Debriefing Position Statement Work Group: Jack Herrmann, John Hickey, Edward M. Kantor, Patricia Santucci, James M. Shultz, and Alan Steinberg.

Additional Resources

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Appendix C: Missing Persons, Bereaveme Death Notification, and Body Identificatio

The PFA provider may lend support and practical assistance to children, adults an the following post-disaster circumstances:

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- When a family member or friend is missing
- When a family member or close friend has died
- When death notification is made
- When body identification is requested
- When body recovery is likely to be delayed

Culture Alert: **Beliefs and attitudes about death, funerals, and expressions of grief are strongly influenced by family, culture, religious beliefs, and rituals related to mourning. You should inform yourself about cultural norms with the assistance of community cultur leaders who best understand local customs. Even within cultural and religious groups, be and practices can vary widely. Do not assume that all members of a given group will beli or behave similarly. It is important for families to engage in their own traditions, practice and rituals to provide mutual support, seek meaning, manage a range of emotional responses and death-related adversities, and honor the death.**

When a Family Member is Missing

Worry about a missing loved one is extremely distressing. Family members may experience of different feelings: worry, hope, anger, turmoil, shock, gratitude, or guilt. They may alterna between certainty that the person is alive - even in the face of contradictory evidence - and hopelessness and despair. They may blame authorities for perceived ineptitude or delays. Th also feel vengeful against those that they consider responsible for their presumed loss and r frustrated by what they consider to be inadequate efforts or resources devoted to locating th relative or friend.

An important way that you can assist family members who have a missing relative, friend or is to help them obtain updated information about the missing person(s). You should be famil the local post-disaster system and locations for updated “debriefings,” and methods for connecting/reuniting survivors. If registries or other mechanisms are available, have family m place their own names in the registry, as well as use it to search for missing loved ones. The register or receive new information is filled with anxiety and apprehension.

The PFA provider, if possible, may want to take extra time with survivors worried over a miss family member. Just being there to listen to their hopes and fears, and being honest in giving information and answering questions is often deeply appreciated.
In assisting family members who may be preoccupied with concerns over a missing loved or PFA provider should help to insure that care is taken to prevent young children from wanderi in what may be a strange environment. Family members should be encouraged to make sure and their children get enough nourishment and sleep.

The PFA provider can review with the family any pre-disaster plans for post-disaster contact, including:

- School or workplace evacuation plans, plans for tracking transport of students or co workers for medical care, and locations set up for reunification
- Out-of-state telephone numbers to be used by schools, workplaces, or families in ca emergency
- Pre-arranged or likely meeting places (including homes of relatives) families may ha established, both within and outside the disaster perimeter

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As local cell phones may not operate after a disaster, if available in the setting, help family m
gain access to working cellular phones to locate a missing loved one or to contact relatives w
worried about them.

Some family members may want to leave a safe area to attempt to find or rescue a missing
As this may not be advisable, the PFA provider should know about the current circumstances
search area. This includes the specific dangers of such a search, needed precautions, and ot
including telling survivors about the efforts of first responders and when updated information
available. Those who may feel most urgent about leaving a safe area include:

- Adults with missing elderly parents
- Parents/caregivers of missing children
- Adolescents with a missing parent or close friend

It may comfort some family members to keep a small personal item and or photograph of th
person with them. When it is feasible, this may be encouraged as an alternative to leaving a
when it is not advisable. It is helpful to discuss specific concerns they may have (e.g., an eld
who recently had hip surgery, or a child who needs special medications) and offer to inform
responder teams.

In some cases, authorities may ask survivors to give information or provide other evidence t
search. Authorities may have family members file a missing persons report or provide inform
about when and where the person was last seen, who else was there, and what he or she wa
is best to limit the exposure of younger children to this process.

It can be disturbing and confusing for a child to be present at a caregiver's interview with au
to hear adult speculations about what might have happened to the person. Authorities may
member to collect DNA from a loved one's personal effects, for example, hair from a hairbru
Observing this can also be disturbing to a young child. It is extremely important to reassure
that the family, police, and other experts are doing everything possible to find the missing lo
In rare cases, a child may need to be interviewed because he/she was the last one to see th
mental health or forensic professional trained to interview children should conduct the interv
present. A supportive family member should always accompany the child. Children should be
about the interview in simple and honest language.

Adolescent/ Child	Uncle Mario is missing. Everyone is working very hard to find out what happened. The police need to ask you some questions. It's okay if you do not remember something. Just tell them that you don't remember. Not remembering something will not hurt (name). Your mom will stay with you while they ask the questions, and I can stay too, if you want. Do you have any questions?

A very young child may provide more useful information if first asked to draw what he/she re
and then talk about the picture.

Forensic experts may seek permission to swab the inside of a family member's cheek to mat
When DNA must be collected from a family member, usually it is taken from the nearest livin
maternal-line relative. All efforts are made to avoid collecting DNA from a child. However, if
is the closest living maternal-line relative, and the family chooses to participate, authorities
to swab the inside of the child's cheek to collect cells or even take blood. If this must be don
should: (1) be explained to the child in simple, honest language; (2) be demonstrated on an
family member; and (3) done gently and slowly, with continuing simple explanations to the c

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In assisting children, adults and families, the PFA provider should repeat and reinforce the in
already provided to the family.

When a Family Member or Close Friend has Died

Acute Grief Reactions are likely to be intense and prevalent among those who have suffered the loss of a loved one or close friend: sadness and anger over the loss, guilt or regret over not having been able to prevent the death, provide comfort, or have a proper leave-taking, missing or longing for the deceased, and strong desires for reunion (including dreams of seeing the person again). Grief reactions vary from person to person and in intensity for years after the loss. There is no single "correct" course of grieving. Importantly, personal, family, religious and cultural factors affect the expression and course of grief. Although painful to experience at first, grief reactions are healthy reactions that reflect the significance of the loss. Over time, grief reactions tend to include more pleasant thoughts and activities, such as telling positive stories about a loved one and finding constructive ways to memorialize or remember him/her. Remember that grief puts people at risk for abuse of over-the-counter medications, increased smoking, and consumption of alcohol. Survivors should be made aware of these risks and the importance of self-care and the availability of professional help.

Treating acutely bereaved children and adults with dignity, respect and compassion is the ov
principle. In working with children and families who have experienced the death of a family
or close friend, the PFA provider can communicate the following to adults, caretakers, and ch

- Family members and friends will each have their own special set of reactions.
- No particular way of grieving is right or wrong.
- Do not expect that there is a "normal" period of time for all types of grief.
- Discuss with family members and friends how culture or religious beliefs influence how
grieve, and especially how the rituals may or may not match current feelings of each f
member.
- Keep in mind that children may only show their grief for short periods of time each day
even though they may play or engage in other positive activities, their grief can be jus
of any other family member.
- Young children often need more than one honest and clear talk about death.
- What is most helpful for family members and friends is to respect and understand how
may be experiencing their own course of grief.
- Some children and adolescents will not have words to describe their feelings of grief a
resist talking with others about how they feel.
- For some children, distracting activities will be more calming rather than conversation
drawing, listening to music, reading, etc.
- Some adolescents may wish to be alone. If safe, provide them with some privacy.

The PFA provider should keep in mind that grief is influenced by: 1) the way that the person died; 2) the kind of supports available from family and friends; 3) prio relationship with the deceased; 4) age and experience with loss; and 5) the felt consequences of the loss for that child, adult or family.

Someone who has lost a family member or close friend may want to talk about the loved on
provider should listen carefully—and with sympathy—for what they have experienced. Do no
that you have to talk a lot. Do not probe. Use the deceased person's name, rather than refer
him/her as "the deceased."

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Don't say:

- I know how you feel.
- It was probably for the best.
- He is better off now.
- It was her time to go.
- At least he went quickly.
- Let's talk about something else.
- You should work towards getting over this.
- You are strong enough to deal with this.
- You should be glad s/he passed quickly.
- That which doesn't kill us makes us stronger.
- You'll feel better soon.
- You did everything you could.
- You need to grieve.
- You need to relax.
- It's good that you are alive.
- It's good that no one else died.
- It could be worse; you still have a brother/sister/mother.
- Everything happens for the best according to a higher plan.
- We are not given more than we can bear.
- (To a child) You are the man/woman of the house now.
- Someday you will have an answer.

If a person who has lost a loved one says any of the above things, you can respectfully *ackn* the feeling or thought (for example, "It's helpful for you to know that he didn't suffer, even t really wish he could have survived"). Just don't *initiate* these statements yourself.

Do:

- Reassure grieving individuals that what they are experiencing is understandable and exp
- Let them know that they will most likely continue to experience periods of sadness, loneli anger.
- Tell them that if they continue to experience feelings of depression beyond three to six m talking to a member of the clergy or to a counselor who specializes in grief is advisable.
- If they have a prior history of significant depression, let them know that they may wish to with someone at even an earlier time.
- Tell them that their doctor should be able to refer them to a counselor. They can also con city or county department of mental health or local hospital for a referral to appropriate s

Physical Touching: Many cultures have strict rules about physical space between people, eye contact, and the appropriateness of physical touching, especially of t opposite sex. Until you become familiar with the rules for the culture of the family you should not approach too closely, make prolonged eye contact, or touch. In working with family members, it is important for the PFA provider to find out who is the spokesperson for the family.

Talking to Children and Adolescents about Death and Loss

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Children's understanding of death varies depending on age and prior experience and is stron influenced by family, religious, and cultural values.

- Pre-school children may not understand that death is permanent, and may believe tha wish it, the person can return. They need help to confirm the physical reality of a perso death—that he/she is no longer breathing, moving or having feelings—and has no disc or pain. They may be concerned about something happening to another family membe
- School-age children may understand the physical reality of death, and think of death a monster or skeleton. In longing for his/her return, they may experience upsetting feeli "ghostlike" presence of the lost person, but not tell anyone.
- Adolescents understand that death is irreversible. Losing a family member or friend ca rage and impulsive decisions, (quitting school, running away, or abusing substances). issues need prompt attention by the family or school.

Losing a parent or guardian affects children differently depending on their age. When a toddler loses a parent/caregiver, he/she needs consistent care and a predictable daily routine as soon as possible. Toddlers are easily upset by change food prepared differently, their special blanket missing, or being put into bed at night without the usual person or in a different way. Caregivers (including the surviving parent) should ask the child if they are doing something differently or something "wrong," (e.g., Am I not doing this the way Mommy did?). A school-age child loses not only their primary caretaker, but also loses the person who would normally be there to comfort him/her and help with daily activities. Other caretakers should try, as best they can, to assume these roles. Children may be angry at a substitute caregiver, especially when disciplined. Caregivers should acknowledge that the child is missing his family member or friend, and then provi extra comfort. A teenager whose parent, sibling, or close friend has died may hav an intense sense of unfairness, and protest over the loss. They may have to take greater responsibilities within their family, and resent not being able to have mor independence. Over time, caregivers should discuss with teens how to balance th different needs.

When assisting parents in talking with their children about death, keep the following in mind

- Be at the child's eye level when talking with them.
- Assure children that they are loved and will be cared for.
- Watch for signs that the child may be ready to talk about what happened.
- Do not make the child feel guilty or embarrassed about wanting to talk.
- Do not push children to talk.
- Give short, simple and honest age-appropriate answers to their questions.
- Listen carefully to their feelings without judgment.
- Reassure them that they did not cause the death, and that it was not a punishment fo that anyone did "wrong."
- Answer questions honestly about funerals, burial, prayer, and other rituals.
- Be prepared to discuss the same things again and again.
- Do not be afraid to say that you don't know the answer to a question.

The PFA provider should give information to parents/caretakers and children about reactions might experience. Children's overt reactions to the loss may be intense and immediate, or a after several days or weeks. Clarifying that each family member should be sensitive to each

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unique experience of grief, and that some may need special attention. Families should know remembering and reminiscing are, and will be an important part of grieving.

When speaking to parents/caretakers, the PFA provider can say:

Parent/ Caregiver	"Although feelings about the loss may be there all the time, there may be moments when you feel it very strongly. Some of these moments everyone will share in common, and it is a good time to give each other extra support and comfort. Some of these moments will be very private for each family member. It is okay to take some time for yourself, but it is often good to let others in the family know when this happens and how they can be of help."

The PFA provider can also add:

Parent/ Caregiver	"It can be helpful to think about times when your children will particularly miss their family member, like at mealtime or bedtime. If you say something like, 'It is hard not to have daddy here with us right now,' you can ease the discomfort everyone is feeling, make children feel less alone, and help them to better handle these difficult times." "When you see a sudden change in your child—looking kind of lost or sad or even angry—and you suspect he/she is missing the family member, let him/her know that you, too, have times when you feel that way. Say something like, 'You seem really sad, I'm wondering if you are thinking about your dad. Sometimes I feel very sad about dad too. It's ok to tell me when you are feeling bad so maybe I can help.' Help by giving them some time alone with those feelings, sitting quietly with them, and giving them a hug."

Let family members know that there may be differences in how much each wants to talk abo loved one. You can say:

Adult/ Adolescent	"Each of you may have different ways to deal with the death right now. Sometimes you will want to talk about person. Other times you will feel like being by yourself and quiet. Family members need to respect what each is feeling so that you do not get upset with each other over differences in how each family member is responding."

Children and adolescents sometimes feel guilty that they have survived while other family m have not. They may believe that they caused the death is some way. Families need to help c children's sense of responsibility, and assure them that in events like this, they are not to bl what happened. For example, you may suggest that a caregiver say:

Parent to Adolescent/ Child	"We all did what we could to try to save everybody. Daddy would be so happy that we are all okay. You did not do anything wrong." Saying this once may not be enough; feelings of guilt may come up again and again, and caretakers need to be able to provide constant assistance with the child's ongoing worries and confusion about guilt.

In the immediate aftermath of loss of a loved one, encourage family members to rely on one for comfort in the weeks and months ahead.

Grief and Spiritual Issues

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Many times during disaster situations, well-meaning religious people seek out survivors in order to proclaim their own religious beliefs about salvation or damnation. If you become aware of activities like this, do not try to intervene; instead notify security personnel or others in charge.

In order to assist families with spiritual needs, the PFA provider should become familiar with who may be part of the disaster response team on-site, and ways to obtain contact informat clergy of local religious groups that you can use for referral purposes.

It is common for families to rely on religious and spiritual beliefs/practices as a way to cope traumatic events. Survivors may use religious language to talk about what is happening or w engage in prayer or other religious practices. It is not necessary for the PFA provider to shar beliefs in order to be supportive. You are not required to do or say anything that violates you beliefs. Often, simply listening and attending is all that is required. Things to keep in mind in

- A good way to broach this topic is to ask, “Do you have any religious or spiritual needs time?” This question is not meant to lead to a theological discussion or to the PFA prov engaging in spiritual counseling. If requested, you can refer them to a pastoral care pr or offer to call a clergyperson or chaplain of their choice.
- Do not contradict or try to “correct” what a person says about their religious beliefs, e disagree and think that it may be causing them distress.
- Do not try to answer religious questions like, “Why was this allowed to happen?” These questions represent expressions of emotion rather than real requests for an answer. O listening and attending is enough and all that is required.
- Do not be drawn into a discussion of religion or put forth your own religious views (i.e. “Everything happens for the best according to a higher plan.”).
- If a person is clearly religious, ask if he/she wants to see a clergy member of their faith assume that a person wants to see a clergy person.
- Many people rely on religious objects such as prayer beads, statues, or sacred texts th may have lost or left behind. Locating an object like this can help to increase their leve security and sense of control. A local clergy person can be of help in providing these it
- Survivors may want to pray alone or in a group. You may help by finding a suitable pla them to do so. For some people, facing in the proper direction while praying is importa can help to orient them.
- You may also provide information to officials in charge regarding space and religious it needed for religious observances.
- If you are asked to join in prayer, you may decline if you feel uncomfortable. Keep in m joining may only involve standing in silence while they pray. If you are comfortable join at the end with an “Amen,” this can help your relationship with the person and the fam
- Many people routinely light candles or incense when they pray. If not allowed in the se explain this to the person, and assist them in finding a nearby place where an open fla be allowed.
- Some people believe in miracles. A survivor may voice hope for a miracle, even in the virtual certainty that their loved one has died. Do not take this as evidence that he/she touch reality or has not heard what has been said, but the survivor’s way of continuing function in devastating circumstances.
- Every religion has specific practices around death, particularly in regard to the care of bodies. Ask survivors about their religious needs in this area. They may want a clergyp advise them.

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- In some cultures, expressions of grief can be very loud and may seem out of control. It helpful to move families to a more private space to prevent them from upsetting other behavior is upsetting to you, you should find someone else to assist the family.

If a survivor expresses anger associated with his/her religious beliefs (a sign of spiritual distr not judge or argue with him/her. Most people are not looking for an "answer," but a willing, n judgmental listener. If spiritual concerns are contributing to significant distress, guilt or funct impairment, you can ask if he/she would like a referral to a pastoral counselor.

Casket and Funeral Issues

Local laws often govern the preparation of a body for burial and rules regarding caskets or in Sometimes exceptions are made for members of particular religious groups. In many jurisdic law requires autopsies for any victim of a traumatic death or when the cause of death is not requirement may be upsetting, especially to members of religious groups that normally proh autopsies. In some jurisdictions, autopsy requirements can be waived by a Medical Examine who do not want an autopsy should be helped to find out about the local law.

When a body has been significantly disfigured, you may suggest that—if it is in keeping with religious tradition of the family—survivors place a photograph of the deceased on the casket to allow mourners to remember the person and pay their respects.

Children's Attendance at a Funeral

The PFA provider can assist family members with their questions about whether children sho the funeral, memorial service, or gravesite. In responding to questions, keep the following in

- It can be helpful to a child to attend a funeral. Even if emotionally challenging, funeral children accept the physical reality of the death that is part of grieving. If not offered t included, children can feel left out of something important to the family.
- Parents/caregivers should give children a choice as to whether they want to attend. Th encourage, but not pressure them.
    - Before asking them to choose, tell them what to expect if they attend, including them know that adults may be upset and crying. Explain that there will be a spe for the family if that is to be arranged. Let them know about things that will happ during the service.
    - Give them an opportunity to help chose a person they feel close to, who can pay appropriate attention to them during the service.
    - Always provide children a way to leave with that person, even temporarily, if the becomes overwhelming.
    - Tell children about alternative arrangements if they do not wish to attend, for ex that they can stay with a neighbor or friend of the family.
    - If they chose not to attend, offer to say something or read something on their be explain how they can participate in a memorial activity at a later time.
- If possible, bring younger children to the location early so that they can explore the sp Describe the casket and, if they wish, join them in approaching it. Caution should be e in regard to allowing young children to view or touch the body. A young child can use a photograph of the person to help them say goodbye.
- For younger children, reinforce that the family member is not in distress.

The PFA provider may be asked to attend funerals or events. You may feel that in attending, further assist a family member or child.

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Traumatic Grief

Alert: Disaster survivors, who have experienced extreme life threat or witnessed t death of their loved one, can become preoccupied with traumatic details of how th person died. This preoccupation, which has been referred to as Traumatic Grief, can change the course of bereavement. Survivors with traumatic grief may not appear to be acutely grieving, but do not confuse a lack of crying or sadness with caring. Help family members understand that each of them will experience his/her own type—and course—of grief reactions depending on the experience of the disaster and the death. Do not delve into the traumatic details of the death, but instead, inform family members that different types of disaster-related experienc can affect grief. The PFA provider can help to promote a family milieu of understanding and tolerance that helps to avoid conflict and estrangement.

After traumatic death, survivors tend to stay focused on the circumstances of the death, incl preoccupied with how the loss could have been prevented, what the last moments were like was at fault. Traumatic grief reactions include:

- Intrusive, disturbing images of the manner of death that interfere with positive remem and reminiscing
- Delay in the onset of healthy grief reactions
- Retreat from close relationships with family and friends
- Avoidance of usual activities because they are reminders of the traumatic loss

Traumatic grief changes mourning, often putting individuals on a different time course than n expected or experienced by other family members. Traumatic grief reactions can clash with of religious rituals and other cultural expressions of mourning. To address issues of traumatic with a family, the PFA provider might say:

Adult/ Adolescent	"It is important to know that what each of you experienced during the disaster may affect how you express your grief. Some of you may not be able to cry, while others might cry a lot. You should not feel badly about this or think there is something wrong with you. Each of you will feel your loss differently. What is most important is to respect the different ways each of you will feel or show your grief and help each other in the days and weeks ahead."

You may want to speak privately to a family member who was present at the time of the dea to advise them about the extra burden of witnessing the death. Let him/her know that talkin mental health professional or clergy may be very helpful. For example, the provider might sa

Adult/ Adolescent	"It is awful to have been there when Joe died. Other family members may want to know details about what happened, but there may be some details that you think will be too upsetting for them. Discussing what you went through with a professional can help you decide what to share with your family and also help you with your grief."

Death Notification

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Although it is unlikely that the PFA provider will be asked to notify a family member of a deat PFA provider may assist family members who have been informed of the high probability, or confirmation, of a death. The PFA provider may be asked by police, FBI, hospital personnel o team members to be present at the time of death notification. You should be aware that in s catastrophic situations, for example airline crashes, the news media may report that there w survivors of the accident. This news is often released before family members have been offic notified that a relative has died. Sometimes incorrect information is circulated by the media survivors—caution family members to wait for official confirmation from the authorities.

After learning of the death of a family member or close friend, people may have psychologic physiological reactions that vary from hyperarousal to numbness. At the same time, they mu with the continuing stress of still being in the disaster environment. In providing support, the provider should keep the following in mind.

- Don’t rush. Family members need time to process the news and to ask questions.
- Allow for initial strong reactions to horrible news concerning the sudden death of a loved Consider these to be normal reactions to a highly abnormal situation, and expect that the recede over time. If medically necessary, ask for assistance from an Emergency Medical Technician (EMT). If family members become highly agitated, get help from authorities to them from hurting themselves or others. Family and friends are critical in these intense s Prior to, during and after death notification, the PFA provider should try to assure that the supports are in place.
- Try to work with individuals and small family units. Even when officials are addressing larg crowds, it is better to have family members assembled at their own tables with the PFA p present. Potentially traumatic activities —such as reviewing passenger manifests, ticket l morgue photos, etc.,—should be done in small family groups, in a private location, with th appropriate authorities, and a PFA provider present.
- There may be a need for immediate decision-making or action following the tragic news. provider can assist family members in clarifying what needs to be done, and what options available. Getting accurate information is crucial. Those who have been traumatized and acutely bereaved may have difficulty in recalling information. Help family members by re information as needed.
- When talking about a person who is a confirmed fatality, use the word “died”, not “lost” o away.”
- Remember that family members do not want to know how you feel (sympathy); they wan you are trying to understand how THEY feel (empathy).
- If you go with family members to a hospital emergency department, ICU or morgue, prep for what they are going to see, hear, smell, etc. If you have already established a support relationship with the family, accompanying them can help them cope with the immediate well as assist them with other tasks to come.
- If possible, try to have the most physically and emotionally stable family member make a identification, or assist family members who must make the identification.
- Encourage the family to minimize children’s exposure to any photographs, artifacts, or re the deceased.

Body Identification

When bodies or partial remains have been recovered, family members may be asked to gath records, x-rays, dental records and articles containing the relative’s DNA (a hair brush, tooth etc.) and bring them to a designated location. Under such circumstances, family members m asked for a sample of their DNA (usually obtained by swabbing the lining of the cheek) provi

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location established for this purpose. A mental health responder is usually present at these l
stations.

Where identifiable bodies have been recovered and family members have been asked to ass
identification process, authorities may take family members to a private location to view pho
of persons who have been brought to the morgue. Once a person is tentatively recognized b
family member may be asked to view the body in the morgue. The body may be behind a gl
partition, mostly covered by a sheet. If the relative has died in the hospital, identification ma
at a designated location in the hospital. Many forensic authorities try to reduce the traumati
seeing a loved one's body in the morgue by using a videotape or still photographs. This also
family members from the strong odor, which can be highly disturbing.

Some may feel that they must see the body before they can accept that the person is dead.
and older children might ask to be present when the body is identified; however, in most cas
health professionals discourage allowing children to be present. Children may not understan
extent to which the body has deteriorated or changed and may find seeing the body extrem
disturbing. This can be upsetting for adults as well. Parents can say to the child:

Parent to Adolescent/ Child	"You know, Uncle Bobby wouldn't want you to see him that way. He'd want you to remember him looking alive and healthy. I'm going to go and make sure that it's him, but I don't feel you should go and see the body."

When the body found is too disfigured for family members to be able to identify it, it is natur
families to want to know when and where the body was found, and what the person experie
dying. Family members may be more disturbed by the unanswered questions, than by havin
questions answered.

The physical confirmation of the death can provoke a range of grief reactions, including shock, numbness, fainting, vomiting, trembling, screaming, or hitting something or someone. Some individuals may be unresponsive, while others may become outraged, cursing about how the person died. You should expect a wide range of reactions, many of which will be quite brief.

Confirming Body Identification to a Child or Adolescent

After a family member has identified the body of a loved one, a parent or closely related car
should convey this to related children. You may sit in to provide support and assistance. Sinc
children don't understand that death is final, a family member should make it very clear tha
missing loved one's body has been found, and that he/she is dead. If the identification was n
through forensic methods, it is important to explain the certainty of the identification in simp
language. The family's belief about death and an afterlife will often be part of this conversat
Parents should reassure the child that the loved one is not suffering, that the child was very
him/her, and that the child will be taken care of. Allow the child to ask questions, and—if an
not readily available—let him/her know that the parent or PFA provider will try to get some a
information. The PFA provider should caution parents or caretakers about giving disturbing d
the physical appearance of the body. If the child asks about the appearance, a parent can sa

Parent to Adolescent/ Child	"It was not easy to see Uncle Jack, and he would want us to remember him alive, and to think about the nice times we spent together. I remember going on hikes and going fishing. You can pick any memory of Uncle Jack that you want to, too. Then we'll both have good ways to think about him."

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Young children may have a range of responses to being told of the death. They may act as if not hear; they may cry or protest the news. They may be angry with the person who told the death. Children need a comforting presence, reassurance that the loved one is not physically and confirmation that they were loved. The PFA provider may suggest that the parent or care say something like:

Parent to Adolescent/ Child	"It is awfully hard to hear that Aunt Julia is really dead. It's okay if you want to cry or if you don't want to cry. Anytime you want to talk about her and what happened, I'm going to be here for that. You'll see me have lots of feelings too. Don't be worried; we can all help each other."

Family members should address children's immediate questions about their living circumsta who will take care of them. In assisting, the PFA provider may suggest that separation of sibl avoided, if at all possible.

The PFA provider can help parents or other family members talk with their adolescent childre Parents should be told that, after experiencing a traumatic loss, it is important to caution tee doing something risky, like storming off, driving while overwhelmed with such news, staying being tempted to use alcohol or other drugs, or acting in some other reckless way. Parents o should also understand that an adolescent's anger can turn to rage over the loss, and they s prepared to tolerate some amount of expression of rage. However, they should also be firm addressing any behavioral risks. Expression of any suicidal thought should be taken seriously appropriate additional assistance should be immediately sought. Expressions of revenge sho taken seriously. Adolescents should be cautioned to think about the consequences of reveng encouraged to consider different constructive ways to respond to their feelings.

The process leading to the confirmation of a relative's sudden death is extremely intense and challenging. Psychological, social and practical support in these situations is critical. In these circumstances, the PFA provider should take cues from the family in regard to how they wish to spend this time. They may want to s in silence, pray, read sacred text, or distract themselves by talking about totally unrelated matters. Distracting activities like games or talking about lighter subje can be an adaptive way of not focusing on their grief.

When a Child has seen a Dead Body (Outside of a Ritual Setting)

In the case of terrorism and disaster, children are sometimes exposed to dead bodies of stra their loved ones. Parents/caretakers should be encouraged to explain to a child why a dead b different from a living person. For example, a body that has been submerged under water lo and discolored. If not explained, the child may come to his/her own even more disturbing co

When Body Recovery is Delayed

Sometimes days or weeks after a person has disappeared with no recovery of the body, the will strongly suggest that the person is dead. Parents/caregivers should not assume that it is child to keep hoping that the person is alive, but instead honestly share this information with Parents should explain to the child, without providing too much detail, that it looks like the lo has died, and that this is what you and the authorities believe has happened.

In some religious and cultural groups, mourning or moving on with life is prohibite until a body is recovered and a funeral held. This practice can cause difficulties fo

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families where the recovery of the body is delayed or never occurs. When the recovery of the body is seriously delayed for a family with these beliefs, the PFA provider should assist the family in consulting with their religious leader.

Not being able to perform burial and other religious rituals can complicate the gri process and increase a family's distress. When there is no body to bury, it is important for families and communities to create other kinds of rituals or memori observances. Having a place to visit that memorializes their loved one is often comforting to families. Parents should include children in these rituals.

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Appendix D: Resources

Training Resources

Advanced Disaster Medical Response: A Manual for Providers

Briggs, S.M., & Brinsfield, K.H., (editors). Harvard Medical International, Inc., 2003.

http://www.amazon.com/gp/product/0972377204/002-8489036-2108026?v=glance&n=283155

Behavioral Health Awareness Training for Terrorism and Disasters

Shultz JM, Espinel Z, Cohen RE, Shaw JA, Flynn BW, Ursano RJ.
Center for Disaster Epidemiology & Emergency Preparedness (DEEP Center), University of Miami School of Medicine, 2005 (first edition 2003).

http://deep.med.miami.edu

Community-based Psychological Support: A Training Manual

Published by the International Federation of Red Cross and Red Crescent Societies, 2003.

http://www.ifrc.org/what/health/psycholog/manual.asp

Disaster Behavioral Health: All Hazards Training

Shultz JM, Espinel Z, Cohen RE, Smith RG, Flynn BW.

Center for Disaster Epidemiology & Emergency Preparedness (DEEP Center), University of Miami School of Medicine, 2006.

http://deep.med.miami.edu

Disaster Behavioral Health OPERATIONS Training for Health Care Professionals

Shultz JM, Espinel Z, Cohen RE, Shaw JA, Flynn BW, Watson PJ, Hick JL, Schreiber M.

Center for Disaster Epidemiology & Emergency Preparedness (DEEP Center), University of Miami School of Medicine, 2005.

http://deep.med.miami.edu

Disaster Mental Health: A Critical Response. A Training for Mental Health Professionals in Commun

Herrmann, J. University of Rochester. 2005

http://www.centerfordisastermedicine.org/community_setting/

Disaster Mental Health: A Critical Response. A Training for Mental Health and Spiritual Care Profes Healthcare Settings

Herrmann, J. University of Rochester. 2006

http://www.centerfordisastermedicine.org/healthcare_setting/

Disaster Mental Health Training: Guidelines, Considerations, and Recommendations

Young, B.H., Ruzek, J.I., Wong, M., Salzer, M.S., and Naturale, A.J. In Interventions Following Mass Violence a Disasters: Strategies for Mental Health Practice. Edited by Elspeth Cameron Ritchie, Patricia J.Watson, and M Friedman. New York: Guilford Publications, 2006.

http://www.istss.org/guilfordDMH.pdf

Disaster Mental Health Response Handbook: An Educational Resource for Mental Health Professior Disaster Management

Centre for Mental Health, NSW Health and NSW Institute of Psychiatry. New South Wales, Australia State He Publication No: (CMH) 00145, 2000.

http://www.nswiop.nsw.edu.au/Resources/Disaster_Handbook.pdf

Disaster Mental Health Services: A Guidebook for Clinicians and Administrators

Young, B.H., Ford, J.D., Ruzek, J.I., Friedman, M.J., & Gusman, F.D. The National Center for Post-Traumatic Stre Disorder, Education & Clinical Laboratory, VA Palo Alto Health Care System, Menlo Park, California 94025; Executive Division, VA Medical & Regional Office Center, ,White River Junction, Vermont 05009, 1998.

http://www.ncptsd.va.gov/publications/disaster/

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[10] Adapted from: Herrmann J. *Disaster Mental Health: A Critical Response. A Training Curriculum for Mental Hea Spiritual Care Professionals in Healthcare Settings*. University of Rochester, 2006.

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Field Manual for Mental Health and Human Service Workers in Major Disasters

DeWolfe, D. J. (author). Nordboe, D. (editor). Department of Health and Human Services, Substance Abuse a Mental Health Services Administration (SAMHSA), Center for Mental Health Services DHHS Publication No. A 90-537, 2000.

http://www.mentalhealth.samhsa.gov/publications/allpubs/ADM90-537/Default.asp

Grief Counseling Resource Guide

Published by the New York State Office of Mental Health (OMH), 2004.

http://www.omh.state.ny.us/omhweb/grief/

Helping to Heal: A Training on Mental Health Response to Terrorism Manual (2004)

Community Resilience Project of Northern Virginia. Commonwealth of Virginia Department of Mental Health Retardation and Substance Abuse Services, January 2004.

http://www.dmhmrsas.virginia.gov/CWD-HelpingToHeal.htm

Mental Health Response to Mass Violence and Terrorism: A Training Manual

U.S. Department of Health and Human Services. DHHS Pub. No. SMA 3959. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2004.

http://www.mentalhealth.samhsa.gov/media/ken/pdf/SMA-3959/MassViolenceAndTerrorism.pdf

National Disaster Mental Health Training Program

U.S. Department of Veterans Affairs, National Center for Post Traumatic Stress Disorder (NCPTSD)

http://www.ncptsd.org/about/training/ndmh_training.html

Psychological First Aid: A Field Operation Guide

Terrorism and Disaster Branch, National Child Traumatic Stress Network, National Center for Post Traumatic Disorder. 2005

http://www.ncptsd.va.gov/pfa/PFA.html

Psychological Intervention for Victims of Mass Terrorism and Trauma

Buetler, L. National Center on the Psychology of Terrorism, Pacific Graduate School of Psychology.

http://www.terrorismpsychology.org

SURGE, SORT, SUPPORT: Disaster Behavioral Health Awareness Training for Health Care Profession

Shultz JM, Espinel Z, Cohen RE, Smith RG, Flynn BW.
Center for Disaster Epidemiology & Emergency Preparedness (DEEP Center), University of Miami School of Medicine, 2005 (first edition 2004).

http://deep.med.miami.edu

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http://www.mentalhealth.samhsa.gov/publications/allpubs/ADM90-538/Default.asp

Triumph Over Tragedy, 2nd Ed. A Community Response to Managing Trauma in Times of Disaster ar

Evans, G.D., & Wiens, B.A., (editors). National Rural Behavioral Health Center, Department of Clinical & Hea Psychology, P.O. Box 100165, Gainesville, FL 32610, January 2004.

http://www.nrbhc.org

Issues and Populations of Special Consideration

An ADA Guide for Local Governments: Making Community Emergency Preparedness and Response Accessible to People with Disabilities (2005)

U.S. Department of Justice, Civil Rights Division, Disability Rights Section

http://www.usdoj.gov/crt/ada/emergencyprep.htm

Assuring Cultural Competence in Disaster Response

The Florida Center for Public Health Preparedness

http://www.fcphp.usf.edu/courses_listings.htm

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Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Reco

U.S. Department of Health and Human Services. Developing Cultural Competence in Disaster Mental. Healt Programs: Guiding Principles and Recommendations. DHHS Pub. No. SMA 3828. Rockville, MD: Center for M Health Services, Substance Abuse and Mental Health Services Administration, 2003.

http://www.mentalhealth.samhsa.gov/media/ken/pdf/SMA03-3828/CulturalCompetence_FINALwithcovers.p

Disaster Mental Health: Crisis Counseling Programs for the Rural Community (1999)

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administrati (SAMHSA), Center for Mental Health Services. DHHS Publication No. SMA 99-3378. Printed in 1999.

http://www.mentalhealth.org/publications/allpubs/sma99-3378/default.asp

Disaster Preparedness for People with Disabilities

American Red Cross national headquarters: Disaster Services, Health and Safety, Services, National Office Volunteers, Office of General Counsel, and Risk, Management Division.

http://www.redcross.org/services/disaster/beprepared/disability.pdf

Helping Children after a Disaster

American Academy of Child & Adolescent Psychiatry, No. 36. Updated July 2004.

www.aacap.org/publications/factsfam/disaster.htm

Mental Health Care for Ethnic Minority Individuals and Communities in the Aftermath of Disasters Violence

Norris, F.H., & Alegria, M. CNS Spectrums. February 2005. Vol. 10, No. 2. p. 132-140.

http://www.cnsspectrums.com/pdf/art_637.pdf

Psychosocial Issues for Children and Families in Disasters: A Guide for the Primary Care Physician

U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Administration (SAMHSA), Center for Mental Health Services.

http://www.mentalhealth.samhsa.gov/publications/allpubs/SMA95-3022/default.asp

Psychosocial Issues for Older Adults in Disasters

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administrati (SAMHSA), Center for Mental Health Services. DHHS Publication No. ESDRB SMA 99-3323

http://media.shs.net/ken/pdf/SMA99-3323/99-821.pdf

Disaster Relief Organizations, Agencies and Programs

American Association of Marriage and Family Therapy (AAMFT)

http://www.aamft.org

American Mental Health Counselors Association

http://www.amhca.org

American Nurses Association

http://www.nursingworld.org/news/disaster

American Psychiatric Association

http://www.psych.org

American Psychological Association (APA)

http://www.apa.org

American Red Cross Disaster Services (ARC)

http://www.redcross.org/services/disaster

Center for Mental Health Services (CMHS)

http://www.mentalhealth.samhsa.gov/cmhs

Department of Health and Human Services (DHHS)

http://www.dhhs.gov

Department of Homeland Security (DHS)

http://www.dhs.gov

Department of Veterans Affairs (VA)

http://www.va.gov/about_va/history

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Disaster Psychiatry Outreach (DPO)
http://www.disasterpsych.org

Federal Emergency Management Agency (FEMA)
http://www.fema.gov

International Society for Traumatic Stress Studies (ISTSS)
http://www.istss.org

Medical Reserve Corps (MRC)
http://www.medicalreservecorps.gov

National Association of Social Workers
http://www.naswdc.org

National Center for Post-Traumatic Stress Disorder (NCPTSD)
http://www.ncptsd.org

National Child Traumatic Stress Network (NCTSN)
http://www.nctsn.org

National Disaster Medical System (NDMS)
http://www.ndms.dhhs.gov

National Organization for Victims Assistance (NOVA)
http://www.dhs.gov

National Voluntary Organizations Active in Disaster (VOAD)
http://www.nvoad.org

New York Disaster Interfaith Services (NYDIS)
http://www.nydis.org

New York State Emergency Management Office (SEMO)
http://www.nysemo.state.ny.us

Office of Victims of Crime (OVC)
http://www.ojp.usdoj.gov/ovc

Project Liberty
http://www.projectliberty.state.ny.us

Substance Abuse and Mental Health Services Administration (SAMHSA)
http://www.samhsa.gov

Planning Tools and Technical Resources

A Guide to the Disaster Declaration Process and Federal Disaster Assistance
Department of Homeland Security, Emergency Preparedness and Response Directorate, Office of Legislative
202-646-4500.
http://www.fema.gove/pdf/rrr/dec_proc.pdf

An ADA Guide for Local Governments: Making Community Emergency Preparedness and Response Accessible to People with Disabilities
U.S. Department of Justice, Civil Rights Division, Disability Rights Section, 2005.
http://www.usdoj.gov/crt/ada/emergencyprep.htm

CDC Public Health Emergency Response Guide for State, Local, and Tribal Public Health Directors
Department of Health and Human Services, Centers for Disease Control and Prevention, 2004.
http://www.bt.cdc.gov/planning/pdf/cdcresponseguide.pdf

Community Guidelines for Developing a Spontaneous Volunteer Plan
Illinois Terrorism Task Force Committee on Volunteers and Donations
http://www.illinoishomelandsecurity.org/pdf/spontvol.pdf

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Crisis Counseling Assistance and Training Program

http://www.mentalhealth.samhsa.gov/cmhs/emergencyservices/progguide.asp

Disaster Nursing and Emergency Preparedness for Chemical, Biological, and Radiological Terrorism Hazards

Veenema, T.G., (editor). New York: Springer Publishing Company, Inc., 2003.

http://www.springerpub.com/prod.aspx?prod_id=21438

Disaster Technical Assistance Center

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administrati (SAMHSA), Center for Mental Health Services

http://www.mentalhealth.samhsa.gov/dtac

Disaster Mental Health Training: Guidelines, Considerations, and Recommendations

Young, B.H., Ruzek, J.I., Wong, M., Salzer, M.S., and Naturale, A.J. In Interventions Following Mass Violence a Disasters: Strategies for Mental Health Practice. Edited by Elspeth Cameron Ritchie, Patricia J. Watson, and J. Friedman. New York: Guilford Publications, 2006.

http://www.istss.org/guilfordDMH.pdf

Federal Family Assistance Plan for Aviation Disasters

Prepared by the National Transportation Safety Board, August 1, 2000.

http://www.ntsb.gov/publictn/2000/SPC0001.pdf

Mental Health All-Hazards Disaster Planning Guidance

U.S. Department of Health and Human Services. DHHS Pub. No. SMA 3829. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2003.

http://media.shs.net/ken/pdf/SMA03-3829/All-HazGuide.pdf

Mental Health and Mass Violence: Evidence-Based Early Psychological Intervention for Victims/Sur Violence

National Institute of Mental Health. NIH Publication No. 02-5138, Washington, D.C.: U.S. Government Printin Office, 2002.

http://www.nimh.nih.gov/publicat/massviolence.pdf

National Incident Management System

Published by the U.S. Department of Homeland Security, March 1, 2004.

http://www.fema.gov/pdf/nims/nims_doc_full.pdf

National Memorial Institute for the Prevention of Terrorism

http://www.mipt.org

National Response Plan

http://www.dhs.gov/dhspublic/interapp/editorial/editorial_0566.xml

New York State County Disaster Mental Health Planning and Response Guide: A Guide for County D Mental Health and Community Services

Herrmann, J., University of Rochester, 2005.

http://www.centerfordisastermedicine.org

Pandemic Influenza

http://pandemicflu.gov/

Preparing for the Psychological Consequences of Terrorism: A Public Health Strategy

Butler, A.S., Panzer, A.M., & Goldfrank, L.R., (editors). Washington, DC: The National Academies Press, 2003

http://books.nap.edu/catalog/10717.html

Robert T. Stafford Disaster Relief and Emergency Assistance Act

United States Code, Title 42. The Public Health and Welfare, Chapter 68. Disaster Relief (As amended by Pu 181, Pub. L. 103-337, and Pub. L. 106-390) Pub. L. 106-390, October 2000, 114 Stat. 1552-1575.

http://www.fema.gov/library/stafact.shtm

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State Mental Health Authorities' Response to Terrorism

National Association of State Mental Health Program Directors, (NASMHPD) Medical Directors Council, 66 Ca
Center Plaza, Suite 302, Alexandria, VA 22314, February 2004.

http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Med%20Dir%20Terrorism%20Rpt%
%20final.pdf

Surge Hospitals: Providing Safe Care in Emergencies

Published by the Joint Commission on Accreditation of Healthcare Organizations, 2006.

http://www.jcaho.org/about+us/public+policy+initiatives/surge_hospital.pdf

Terrorism and Disaster Management: Preparing Healthcare Leaders for the New Reality

McGlown, K. J., (editor). Published by the Foundation of the American College of Healthcare. Chicago: Health
Administration Press, 2004.

Trauma and Disaster: Response and Management

Ursano, R., & Norwood, A.E. (editors). Review of Psychiatry Series, Volume 22, Number 1; Oldham, JM & Riba
M.B., (series editors). Washington, DC: American Psychiatric Publishing, 2003.

Risk Communication

Communicating in a Crisis: Risk Communication Guidelines for Public Officials

U.S. Department of Health and Human Services (SAMHSA), Substance Abuse and Mental Health Services
Administration, 5600 Fishers Lane, Room 17C-26, Rockville, MD 20857, 2002.

http://www.riskcommunication.samhsa.gov/index.htm

Crisis & Emergency Risk Communication: By Leaders for Leaders, Course Book and Participants Ma

U.S. Department of Health and Human Services (HHS) in partnership with the Centers for Disease Control a
Prevention (CDC) Public Health Practice Program Office and the CDC Office of Communication (OC), Office o
Director (OD).

http://www.cdc.gov/communication/emergency/leaders.pdf
http://www.cdc.gov/communication/emergency/part_man.pdf

Effective Media Communication During Public Health Emergencies, WHO Handbook, Field Guide, ar

Published by the World Health Organization, 2005.

http://www.who.int/csr/resources/publication

Terrorism and Other Public Health Emergencies: A Reference Guide for Media

Office of the Assistant Secretary for Public Affairs, U.S. Department of Health and Human Services, Washing
September 2005.

http://www.hhs.gov/emergency/mediaguide/PDF/HHSMedisReferenceGuideFinal.pdf

WHO Outbreak Combination Guidelines

Published by the World Health Organization, 2005.

http://www.who.int/infectious-disease-news/IDdocs/whocds200528/whocds200528en.pdf

WHO Outbreak Communication, WHO Handbook for Journalists: Influenza Pandemic

Published by the World Health Organization, 2005.

http://www.who.int/csr/don/Handbook_influenza_pandemic_dec05.pdf

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Appendix E: Handouts

The following handouts were prepared by the National Child Traumatic Stress Network (NCTS and the National Center for PostTraumatic Stress Disorder (NCPTSD) for the Medical Reserve Corps.

ALCOHOL, MEDICATION, AND DRUG USE AFTER DISASTER

CONNECTING WITH OTHERS: SEEKING SOCIAL SUPPORT

CONNECTING WITH OTHERS: GIVING SOCIAL SUPPORT

TIPS FOR RELAXATION

WHEN TERRIBLE THINGS HAPPEN

TIPS FOR HELPING ADOLESCENTS AFTER DISASTERS (PART I & II)

TIPS FOR HELPING PRE-SCHOOL AGE CHILDREN AFTER DISASTERS (PART I & II)

TIPS FOR HELPING SCHOOL AGE CHILDREN AFTER DISASTERS (PART I & II)

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ALCOHOL, MEDICATION, AND DRUG USE AFTER DISASTER

Some people increase their use of alcohol, prescription medications or other substances after a disas
may feel that using drugs and alcohol seem to help you escape bad feelings or physical symptoms r
stress responses (e.g., headaches, muscle tension). However, they can actually make these things w
the long term because they interrupt natural sleep cycles, create health problems, interfere with
relationships, and create potential dependence on the substance. If your use of alcohol or drugs has
increased since the disaster or is causing problems for you, it is important for you to reduce your lev
or seek help in gaining control over your use.

Managing alcohol, medication, and drug use

- Pay attention to any change in your use of alcohol and/or drugs.
- Correctly use prescription and over-the-counter medications as indicated.
- Eat well, exercise, get enough sleep, and use your family and others for support.
- If you feel like using larger amounts of either prescribed or over-the-counter medications, consult a healthcare professional.
- Consult with a healthcare professional about safe ways to reduce anxiety, depression, muscle tension, and sleep difficulties.
- If you find that you have greater difficulty controlling alcohol/substance use since the hurricane, seek support in doing so.
- If you believe you have a problem with substance abuse, talk to your doctor or counselor about it.

If you have had an alcohol, medication, or drug problem in the past

For people who have successfully stopped drinking or using drugs, experiencing a disaster can some
result in strong urges to drink or use again. Sometimes it can lead them to strengthen their commit
recovery. Whatever your experience, it is important to consciously choose to stay in recovery.

- Increase your attendance at substance abuse support groups.
- If you are receiving disaster crisis counseling, talk to your counselor about your past alcohol or drug use.
- If you have been forced to move out of your local community, talk to disaster workers about helping to locate nearby alcohol or drug recovery groups, or ask them to help organize a new support group.
- Talk with family and friends about supporting you to avoid use of alcohol or substances.
- If you have a 12-Step sponsor or substance abuse counselor, talk to him or her about your situation.
- Increase your use other supports that have helped you avoid relapse in the past.

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CONNECTING WITH OTHERS
SEEKING SOCIAL SUPPORT

- Making contact with others can help reduce feelings of distress
- Children and adolescents can benefit from spending some time with other similar-age peers
- Connections can be with family, friends, or others who are coping with the same traumatic event

Social Support Options

- Spouse or partner
- Trusted family member
- Close friend
- Priest, Rabbi, or other clergy
- Doctor or nurse
- Crisis counselor or other counselor
- Support group
- Co-worker
- Pet

Do . . .

- Decide carefully whom to talk to
- Decide ahead of time what you want to discuss
- Choose the right time and place
- Start by talking about practical things
- Let others know you need to talk or just to be with them
- Talk about painful thoughts and feelings when you're ready
- Ask others if it's a good time to talk
- Tell others you appreciate them listening
- Tell others what you need or how they could help—one main thing that would help you right now

Don't . . .

- **Keep quiet because you don't want to upset others**
- Keep quiet because you're worried about being a burden
- **Assume that others don't want to listen**
- Wait until you're so stressed or exhausted that you can't fully benefit from help

Ways to Get Connected

- Calling friends or family on the phone
- Increasing contact with existing acquaintances and friends
- Renewing or beginning involvement in church, synagogue, or other religious group activities
- Getting involved with a support group
- Getting involved in community recovery activities

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CONNECTING WITH OTHERS
GIVING SOCIAL SUPPORT

You can help family members and friends cope with the disaster by spending time with them and list carefully. Most people recover better when they feel connected and understood to others who care a Some people choose not to talk about their experiences very much, and others may need to discuss experiences on numerous occasions. Talking about things that happened because of the disaster car seem less overwhelming. At times, just spending time with people one feels close to and accepted b having to talk, can feel best. Here are some things we know about giving social support to other peo disasters.

Reasons Why People May Avoid Social Support

- Not knowing what they need
- Not wanting to burden others
- Wanting to avoid thinking or feeling about the event
- Feeling embarrassed or "weak"
- Doubting it will be helpful, or that others won't understand
- Feeling that others will be disappointed or judgmental
- Feeling they will lose control
- Having tried to get help and felt that it wasn't there before
- Not knowing where to get help

Good Things to Do When Giving Support

- Show interest, attention, and care
- Show respect for individuals' reactions and ways of coping
- Talk about expectable reactions to disasters, and healthy coping
- Find an uninterrupted time and place to talk
- Acknowledge that this type of stress can take time to resolve
- Believe that the other is capable of recovery
- Be free of expectations or judgments
- Help brainstorm positive ways to deal with their reactions
- Offer to talk or spend time together as many times as is needed

Things That Interfere with Giving Support

- **Rushing to tell someone that he or she will be okay or that they should just "get over it"**
- **Acting like someone is weak or exaggerating because he or she isn't coping as well as you a**
- Discussing your own personal experiences without listening to the other person's story
- Giving advice without listening to the person's concerns or asking the person what works for him or her
- Stopping the person from talking about what is bothering them
- Telling them they were lucky it wasn't worse

When Your Support is Not Enough…

- Let the person know that experts think that avoidance and withdrawal are likely to increase distress, and social support helps recovery
- Encourage the other to talk with a counselor, clergy, or medical professional, and offer to accompany them
- Encourage the other to get involved in a support group with others who have similar experiences
- Enlist help from others in your social circle so that you all take part in supporting the other

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TIPS FOR RELAXATION

Tension and anxiety are common after disasters. Unfortunately, they can make it more diffic with the many things that must be done to recover. There is no easy solution to coping with disaster problems, but taking time during the day to calm yourself through relaxation exercis make it easier to sleep, concentrate, and have energy for coping with life. These can include relaxation exercises, breathing exercises, meditation, swimming, stretching, yoga, prayer, ex listening to quiet music, spending time in nature, and so on. Here are some basic breathing that may help:

FOR YOURSELF:

1. Inhale slowly (one-thousand one; one-thousand two; one-thousand three) through your nose and comfortably fill your lungs all the way down to your belly.

2. Silently and gently say to yourself, "My body is filled with calmness." Exhale slowly (one-thousand one, one-thousand two, one-thousand three) through your mouth and comfortably empty your lungs all the way down to your abdomen.

3. Silently and gently say to yourself, "My body is releasing the tension."

4. Repeat five times slowly and comfortably.

5. Do this as many times a day as needed.

FOR CHILDREN:

Lead a child through a breathing exercise:

1. “Let’s practice a different way of breathing that can help calm our bodies down.
2. Put one hand on your stomach, like this [demonstrate].
3. Okay, we are going to breathe in through our noses. When we breathe in, we are going with a lot of air and our stomachs are going to stick out like this [demonstrate].
4. Then, we will breathe out through our mouths. When we breathe out, our stomachs ar suck in and up like this [demonstrate].
5. We are going to breathe in really slowly while I count to three. I’m also going to count while we breathe out really slowly.
6. Let’s try it together. Great job!”

Make a game of it:

- Blow bubbles with a bubble wand and dish soap
- Blow bubbles with chewing gum
- Blow paper wads or cotton balls across the table
- Tell a story where the child helps you imitate a character who is taking deep breaths (i.e., little pigs)

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education and coping support

When Terrible Things Happen

What You May Experience

Intrusive reactions

- Distressing thoughts or images of the event while awake or dreaming
- Upsetting emotional or physical reactions to reminders of the experience
- Feeling like the experience is happening all over again (“flashback”)

Avoidance and withdrawal reactions

- Avoid talking, thinking, and having feelings about the traumatic event
- Avoid reminders of the event (places and people connected to what happened)
- Restricted emotions; feeling numb
- Feelings of detachment and estrangement from others; social withdrawal
- Loss of interest in usually pleasurable activities

Physical arousal reactions

- Constantly being "on the lookout" for danger, startling easily, or being jumpy
- Irritability or outbursts of anger
- Difficulty falling or staying asleep, problems concentrating or paying attention

Trauma and Loss reminders

- Places, people, sights, sounds, smells, and feelings that remind you of trauma or loss
- Can bring on distressing mental images, thoughts, and emotional/physical reactions
- Common examples include: sudden loud noises, destroyed buildings, the smell of fire, sirens of ambulan locations where they experienced the trauma, seeing people with disabilities, funerals, anniversaries of t and television/radio news about the trauma

What Helps

Talking to another person for support

- Engage in positive distracting activities (sports, hobbies, reading)
- Getting adequate rest and eating healthy meals
- Trying to maintain a normal schedule
- Scheduling pleasant activities

Spending time with others

- Using relaxation methods (breathing exercises, meditatio calming self-talk)
- Participating in a support group
- Exercising in moderation
- Keeping a journal

Taking breaks

Seeking counseling

What Doesn’t Help

- Using alcohol or drugs to cope
- Withdrawing from family or friends
- Overeating or failing to eat
- Withdrawing from pleasant activities
- “Workaholism”
- Anger or violence
- Doing risky things
- Blaming others
- Extreme avoidance of thinking or talking about the event
- Not taking care of yourself
- Excessive TV or computer games

The National Child Traumatic Stress Network

NCTSN

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NCTSN The National Child Traumatic Stress Network

Tips for Helping Adolescents After Disasters (Par

Reactions	Responses	Example
Detachment, shame, and guilt	►Provide a safe time to discuss with your teen the event and their feelings. ►Emphasize that these feelings are common, and correct excessive self-blame with realistic explanations of what actually could have been done.	► "Many kids—ar and blaming them You're not at fault said there was no
Self-consciousness about their fears, sense of vulnerability, fear of being labeled abnormal	►Help teens understand that these feelings are common. ►Encourage relationships with family and peers for needed support during the recovery period.	► "I was feeling t Most people feel if they look calm ► "My cell phone if you can get a h ► "And thanks fo sister. She's much
Acting out behavior; using alcohol and drugs, sexual acting out, accident-prone behavior.	►Help teens understand that acting out behavior is a dangerous way to express strong feelings (like anger) over what happened. ►Limit access to alcohol and drugs. ►Talk about the danger of high-risk sexual activity. ►On a time-limited basis, have them let you know where they are going and what they're planning to do.	► "Many teens—a and angry after a or taking drugs w feel that way—bu ► "It's important you are and how extra checking-in stabilized.
Fears of recurrence and reactions to reminders	►Help to identify different reminders (people, places, sounds, smells, feelings, time of day) and to clarify the difference between the event and the reminders that is different after it. ►Explain to teens that media coverage of the disaster can trigger fears of it happening again.	► "When you're r to yourself, 'I am up but it is different I am safe." ► Suggest "Watch worse, because th and over. How ab

Tips for Helping Adolescents After Disasters (Par

Reactions	Responses	Examples of thi
Abrupt shifts in interpersonal relationships: Teens may pull away from parents, family, and even from peers; they may respond strongly to parent's reactions in the crisis.	►Explain that the strain on relationships is expectable. Emphasize that we need family and friends for support during the recovery period. ►Encourage tolerance for different family member's courses to recovery. ►Accept responsibility for your own feelings.	►Spend more time talking as a fam ►"You know, the fact that we're ►You might say, "I appreciate your ►"I want to apologize for being irri
Radical changes in attitude	►Explain that changes in people's attitudes after a disaster are common, but will go back to normal over time.	►"We are all under great stress. W ►"I know we all feel more scared, angr
Wanting premature entrance into adulthood (e.g., wanting to leave school, get married)	►Encourage postponing major life decisions. Find other ways to make the adolescent feel more in control over things.	► "I know you're thinking about qu ►"This is not a great time to make m
Concern for other victims and families	►Encourage constructive activities on behalf of others, but do not burden with undo responsibility.	►Help teens to identify projects th (e.g., clearing rubble from school g for those in need).

Tips for Helping Preschool-Age Children After Disaste

Reactions/Behavior	Responses	Examples of t
Helplessness and Passivity: Young children know they can't protect themselves. In a disaster they feel even more helpless. They want to know their parents will keep them safe. They might express this by being unusually quiet or agitated.	►Provide comfort, rest, food, warmth, and opportunities for play and sharing. ►Provide ways to turn spontaneous drawing or playing from traumatic events to include something that would make them feel safer or better. ► Reassure your child that you and other grownups will protect them.	►Give your child more hugs ►Make sure there is a spec with proper supervision. ►In play, a four year old ke down by hurricane winds. A the winds?" the child quick and says, "Winds won't get with, "That wall sure is stro of things to keep us safe."
General Fearfulness: Young children may become more afraid of being alone, being in the bathroom, going to sleep, or other times separated from parents. Children want to believe that their parents can protect them in all situations and that other grownups, such as teachers or police officers, are there to help them.	►Be as calm as you can with your child. Try not to voice your own fears in front of your child. ►Help children regain confidence that you aren't leaving them and that you can protect them. ►Remind them that there are people working to keep families safe, and that your family can get more help if you need to. ►If you leave, reassure your children you will be back. Tell them a realistic time in words they understand, and be back on time. ►Give your child ways to communicate their fears to you.	► Be aware when you are c that your child does not ov ►Say things such as, "We a people are working hard to ►Say, "If you start feeling n hand. Then I'll know you ne
Confusion about the danger being over: Young children can overhear things from adults and older children, or see things on TV or just imagine that it is happening all over again. They believe the danger is closer to home, even if it happened further away.	►Give simple, repeated explanations as needed, every day. Make sure they understand the words you are using. ►Find out what other words or explanations they have heard and clarify inaccuracies. ►If you are at some distance from the danger, it is important to tell your child that the danger is not near you.	►Continue to explain to you passed and that you are aw ►Draw, or show on a map, disaster area, and that whe hurricane was way over the safe place."

Tips for Helping Preschool-Age Children After Disaste

Reactions/Behavior	Responses	Examples of things t
Not talking: Being silent or having difficulty saying what is bothering them.	►Put common feelings of children into words such as anger, sadness, and worry about the safety of parents, friends and siblings. ►Do not force them to talk, but let them know they can talk to you any time.	►Draw simple "happy faces" for dif plates. Tell a brief story about each when the water came into the hous like this?" ►Say something like, "Children can their home is damaged." ► Provide art or play materials to h themselves. Then use feeling words felt. "This is a really scary picture. W you saw the water?"
Fears the disaster will return: When having reminders--seeing, hearing, or otherwise sensing something that reminds them of the disaster.	►Explain the difference between the event and reminders of the event. ►Protect children from things that will remind them as best you can.	►"Even though it's raining, that do is happening again. A rainstorm is s storm like a hurricane can." ► Keep your child from seeing telev computer images of the disaster th happening again."
Sleep problems: fear of being alone at night, sleeping alone, waking up a lot, having bad dreams.	►Reassure your child that s/he is safe. Spend extra quiet time together at bedtime. ►Let the child sleep with a dim light on, or sleep with you for a limited time. ►Some might understand an explanation of the difference between dreams and real life.	►Provide calming activities before b story with a comforting theme. ►At bedtime say, "You can sleep wi tomorrow you'll sleep in your own b ►"Bad dreams come from our thou scared, not from real things happen
Returning to earlier behaviors: Thumb sucking, bedwetting, baby-talk, need to be in your lap	►Remain neutral or matter-of-fact, as best you can, as these may continue a while after the disaster.	►If your child starts bedwetting, ch Stress without comment. Don't let a the child by saying, "You're such a
Not understanding about death: Preschool age children don't understand that death is not reversible. They have "magical thinking" and might believe their thoughts caused the death. The loss of a pet may be very hard on a child.	►Give age-appropriate consistent explanations that do not give false hopes--about the reality of death. ►Don't minimize their feelings over a loss of a pet or a special toy. ►Take cues from what your child seems to want to know. Answer simply and ask if he has any more questions.	►Allow children to participate in cu of grieving rituals. ►Help them find their own way to s a happy memory or lighting a cand the pet. ►"No, Pepper won't be back, but w and talk about him and remember was." ► "The firefighter said no one could wasn't your fault. I know you miss h

Tips for Helping School-Age Children After Disasters

Reactions	Responses	Examples of thing
Confusion about what happened	►Give clear explanations of what happened whenever your child asks. Avoid details that could scare your child. Correct any information that your child is unclear or confused about regarding if there is a present danger. ►Remind children that there are people working to keep families safe and that your family can get more help if needed. ►Let your children know what they can expect to happen next.	► "I know other kids said th would, but we are now in a hurricanes." ►Continue to answer questi (without getting irritable) ar family is safe. ►Tell them what's happenin issues regarding school and living.
Feelings of being responsible: School-age children may have concerns that they were somehow at fault, or should have been able to change what	►Provide opportunities for children to voice their concerns to you. ►Offer reassurance and tell them why it was not	►Talk Take your child aside. Exp disaster like this, lots of kids keep thinking 'What could I

happened. They may hesitate to voice their concerns in front of others.	their fault.	or 'I should have been able doesn't mean they were at ► "Remember? The firefight save Pepper and it wasn't y
Fears of recurrence of the event and reactions to reminders	►Help child to identify reminders (people, places, sounds, smells, feelings, time of day) and to clarify the difference between the event and the reminders that occur after it. ►Reassure them, as often as they need, that they are safe. ►Protect children from seeing media coverage of the event as it can trigger fears of the disaster happening again.	► When they recognize that reminded, say, "Try to think because I am being remind because it is raining, but no and I am safe." ► "I think we need to take a right now."
Retelling the event or playing out the event over and over	►Permit the child to talk and act out these reactions. Let them know that this is normal. ►Encourage positive problem-solving in play or drawing.	► "I notice you're drawing a happened. Did you know th that?" ► "It might help to draw ab your school to be rebuilt to

Tips for Helping School-Age Children After Disasters

Reactions/Behavior	Responses	Examples of thing
Fear of being overwhelmed by their feelings.	►Provide a safe place for them to express their fears, anger, sadness, etc. Allow children to feel or be sad; don't expect them to be brave or tough.	►"When scary things happ feelings, like being mad at e sad. Would you like to sit he you're feeling better?"
Sleep problems, including bad dreams, fear of sleeping alone, demanding to sleep with parents.	►Let your child tell you about the bad dream. Explain that bad dreams are normal and they will go away. Do not ask the child to go into too much details of the bad dream.	► "That was a scary dream. good things you can dream back until you fall asleep."
Concerns about the safety of themselves and others.	►Help them to share their worries and give them realistic information.	►Create a "worry box" whe out their worries and place time to look these over, pro up with answers to the wor
Altered behavior: Unusually aggressive or restless behavior.	►Encourage the child to engage in recreational activities and exercise as an outlet for feelings and frustration.	►"I know you didn't mean t us and be hard to feel so ang ► "How about if we take a w getting our bodies moving h feelings."
Somatic complaints: Headaches, stomachaches, muscle aches for which there seem to be no reason.	►Find out if there is a medical reason. If not, provide comfort and assurance that this is normal. ►Be matter-of-fact with your child; giving these non-medical complaints too much attention may increase them.	►Make sure the child gets e drinks plenty of water, and ►"How about sitting over t better, let me know and we
Closely watching a parent's responses and recovery: not wanting to disturb parent with their own worries.	►Give children opportunities to talk about their feelings as well as your own. ►Remain as calm as you can, so as not to increase your child's worries.	►"Yes, my ankle is broken, b the paramedics wrapped it. hurt, wasn't it?"
Concern for other victims and families.	►Encourage constructive activities on behalf of others, but do not burden with undo responsibility.	►Help children identify proj appropriate and meaningfu from school grounds, collec for those in need).

Appendix F: Working with Older Adults

Older adults have areas of strength as well as vulnerability. Many elderly individuals can be highly resilient, having acquired effective coping skills through a lifetime of experience in dealing with adversity. Alternatively, some may be more vulnerable to stress due to a variety of age-related impairments.

Factors contributing to strength in the elderly include:

- Having effective coping skills (mature perspective, patience, faith, interpersonal skills)
- Having a supportive network of family, friends, neighbors, community groups, and organiz

Factors that may increase vulnerability to stress in the elderly include:

- Health problems such as: physical illness; problems with blood pressure, fluid and electrol falls, minor injuries and bruising)
- Age-related sensory loss:
  - Visual loss, which can limit awareness of surroundings and add to confusion
  - Hearing loss, resulting in gaps in understanding of what others are saying
- Cognitive problems, such a difficulty with attention, concentration and memory
- Dependency on prescription or other medications
- Being on a fixed or low income
- Social isolation, separation from close family members and friends
- Lacking mobility and/or transportation

In working with older adults, the PFA provider should keep the following in mind:

- Talk at eye level, allowing him/her to see your lips when you speak
- Speak clearly and in a low pitch
- Don’t make assumptions based only on physical appearance or age, such as that a confus confusion may include: disaster-related disorientation due to change in surroundings; poo dehydration; sleep deprivation; a medical condition or problems with medications; social i
- Speak to the elderly person, unless direct communication is difficult
- In general, take the word of a person who claims to have a disability, even if the disability
- When you are unsure of how to help, ask, “What can I do to help?” and trust what the per
- Where possible, enable the person to be self sufficient
- An elderly person with a psychiatric or emotional disability may be more upset or confuse such an individual, help to make arrangements for a mental health consultation or referra

To provide effective assistance, you can:

- *Safety:* Help to make the physical environment safer, (for example, try to insure adequate
and falling.
- *Sensory:* Ask specifically about his/her needs for eyeglasses, hearing aids, or other medic
- *Assistance with Physical Tasks:* Ask whether the elder needs help with health-related issue
dressing, use of bathroom, daily grooming, meals; supportive clothing; walker, cane).
- *Medications and Medical Equipment:* Inquire about medications—ask if he/she has a list of
information can be obtained. Make sure he/she has a readable copy of this information to
whether he/she needs medical equipment or supplies (for example, medications, oxygen a
aids are kept with the person.
- *Advocacy/Monitoring:* If available, contact relatives to insure safety, nutrition, medications
- Make sure that the authorities are aware of any daily needs that are not being met.
- *Housing/Discharge:* Help with plans for an elder who is going home or needs access to alt
referral sources for the following, if needed: