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Disaster Relief and Psychological First Aid

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Disaster Relief and Psychological First Aid

by

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the requirements for the degree of
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Each person whose signature appears below certifies that this doctoral project in his/her opinion is adequate, in scope and quality, as a doctoral project for the degree Doctor of Psychology.

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ABSTRACT

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by

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Many organizations that assist in the aftermath of disasters often do not provide psychological relief. Although people tend to be rather resilient in the face of traumatic events, the psychological distress and possible psychopathology that can ensue should not be taken lightly. This manual was created to be used as a training tool for those involved in disaster relief and aid work. A review of the literature, mental health disorders, basic information about disasters, common stress reactions, and Psychological First Aid are included. Although Psychological First Aid has not really been systematically studied, it appears to be promising in aiding trauma survivors.

CHAPTER 1

INTRODUCTION

Clinical Importance of Problem

Many people are exposed to at least one potentially traumatic event at some point in the course of their lives, whether it be war, terrorism, natural disasters, violence, death of a family member, and so on (Bonanno, 2004). Fortunately, the vast majority of individuals have the resilience needed in order to endure such traumatic events with little to no apparent disruption in their psychosocial functioning (Bonanno, 2004; Masten, 2001). However, others go through a period of some psychopathology, such as depression, anxiety, posttraumatic stress disorder, or conduct disorder, among others (Ruzek, Brymer, Jacobs, Layne, Vernberg, & Watson, 2007; Bolton, Hill, O'Ryan, Udwin, Boyle, & Yule, 2004; Joshi & O'Donnell, 2003). Disregarding the smaller percentage of those that do experience psychopathology would be harmful neglect. Not everyone is able to be resilient when faced with trauma – they must be provided some relief from their distress. Although there are numerous organizations that are helpful in providing aid after a traumatic event, they usually do not aid in the psychological care of trauma. It is far more typical for organizations to provide emergency medical services and supplies; access to clean water and food; emergency shelters or transitional shelters; and various supplies, such as tarps, cooking items, and hygiene items (American Red Cross, 2013; Relief International, 2010; Mercy Corps, 2013; Adventist Development and Relief Agency, n.d.). Some organizations that do offer counseling may bring "spiritual comfort and emotional support," such as The Salvation Army counselors, who "are often ordained as clergy (officers)" (The Salvation Army, 2013). Thus, individuals involved in

disaster relief and aid work, both local and international, must be trained and equipped with the basics of psychological first aid. They will then be adequately equipped in providing relief to those with psychological distress and aid in the recovery process.

Aim of Study

The aim of this project is to provide a manual that will educate and prepare individuals in disaster relief or aid work to assist those who have survived a potentially traumatic event. The manual will be a means to give brief psychoeducation on trauma, the possible psychopathologies that can ensue, and basic steps and actions necessary for providing psychological first aid.

CHAPTER 2

REVIEW OF THE LITERATURE

Crisis and Resilience

A crisis occurs when an individual is unable to effectively cope in the face of a stressful life event that is perceived as challenging or as a threat (Flannery & Everly, 2000). More specifically, the individual's psychological homeostasis is disrupted, his or her usual coping mechanisms no longer work to reestablish psychological homeostasis, and the subsequent distress of the crisis has resulted in functional impairment. The stressor event of a crisis is referred to as a "critical incident," which can include motor vehicle accidents, natural disasters, military combat, sexual assault, and so on. Crucial to emergency mental health providers is the potential that these critical incidents can lead to a crisis response. This is of concern when in the course of a normal lifespan, more than two thirds of the population, or possibly even closer to 90% of the population, are likely to be exposed to trauma (Neria, Nandi, & Galea, 2007; Gill, Szanton, Taylor, Page, & Campbell, 2009; Breslau, 2002). Fortunately, most people are able to survive traumatic events with no lasting psychological damage (Bonanno, 2004). However, a smaller percentage experiences a temporary disruption in their normal functioning, which can lead to psychological distress and even psychopathology. There are a variety of disturbances that an individual can experience, which includes: acute stress disorder, posttraumatic stress disorder, depression, anxiety, suicidal ideation, substance abuse, and physical health problems. These individuals must then go through a recovery process in order to return to normal functioning.

Acute Stress Disorder

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR*; American Psychiatric Association, 2000), acute stress disorder is defined as an event that exposes an individual to serious threat of injury or death, with the resulting response being of intense fear, hopelessness, or horror. This disorder is defined by four symptoms clusters: dissociative symptoms, re-experiencing of trauma, avoidance of trauma-associated stimuli, and hyperarousal. In addition, the duration of these symptoms must be present for a minimum of two days and a maximum of four weeks, all occurring within four weeks of the traumatic event. This would include subjective sense of numbing and detachment, a reduction in awareness of surroundings, dissociative amnesia, recurrent images or flashback episodes, exaggerated startle response, motor restlessness, difficulty sleeping, poor concentration, and so on.

According to the *DSM-IV-TR*, the prevalence of acute stress disorder is not known because it depends on the "severity and persistence of the trauma and the degree of exposure to it" (2000). However, it does state that in a few studies, the prevalence rates range from 14% to 33%.

Posttraumatic Stress Disorder

According to the *DSM-IV-TR*, posttraumatic stress disorder, or PTSD, is very similar to acute stress disorder. PTSD is also defined as an event that exposes an individual to serious threat of injury or death, with the resulting response being of intense fear, hopelessness, or horror. This disorder is defined by three symptom clusters: re-experiencing of trauma, avoidance of trauma-associated stimuli, and hyperarousal. In addition, these disturbances must have had a duration of longer than 1 month. This would

include recurrent and intrusive recollections and dreams of the event, intense psychological distress upon exposure to trauma-related stimuli, avoidance of reminders of the event, inability to recall aspects of the event, inability to have loving feelings, feelings of detachment from others, emotional numbing, exaggerated startle response, hypervigilance, difficulty sleeping, and so on.

The overall lifetime prevalence rate for PTSD is about 6.8% or 7.8% (Keane, Marshall, & Taft, 2006). The *DSM-IV-TR* states that the lifetime prevalence in the United States for PTSD is approximately 8% of the adult population. According to epidemiologic data by Breslau et al. in 1998 and by Kessler, Sonnega, Bromet, Hughes, and Nelson in 1995, 8% to 18% of individuals faced with trauma will develop PTSD (as cited in Grant, Beck, Marques, Palyo, & Clapp, 2008). Although more men are exposed to traumatic events (60%) than women (51%), more women develop PTSD (10.4%) than men (5.0%; Keane et al., 2006; Mueser, S. Rosenberg, & H. Rosenberg, 2009). In addition, PTSD prevalence rates appear to increase with the age of the individual, with adolescents at 1.7%, young adults at 7.8%, and 9.2% for adults aged 15-54 years (Hapke, Schumann, Rumpf, John, & Meyer, 2006).

As Bonanno (2004) points out, and as the prevalence rates illustrate, many individuals do not develop PTSD. However, for those that do experience PTSD, the effects that it can have on interpersonal relationships, psychosocial well-being, society, and physical health should not be dismissed (Keane et al., 2006).

Although PTSD is the most prevalent disorder that occurs after a traumatic event, studies by Sierles et al.; Davidson et al.; Health Status of Vietnam Veterans; Green et al.; McFarlane and Papay; Mellman et al.; and Kessler et al. demonstrate that comorbidity is

also quite common (as cited in Bleich, Koslowsky, Dolev, & Lerer, 1997). For example, PTSD has high comorbidity rates with Major Depressive Disorder (MDD) and General Anxiety Disorder (GAD; Grant et al., 2008). MDD and GAD are common disorders that occur in the aftermath of a trauma, according to studies by Franklin and Zimmerman; Green, Lindy, Grace, and Gleser; and Kessler et al. (as cited in Grant et al., 2008). While these disorders share many similar symptoms, studies indicate that the high comorbidity rates are independent of symptom overlap (Shalev, Freedman, Peri, Brandes, Sahar, Orr, & Pitman, 1998; Grant et al., 2008). Thus, disorders that co-exist with PTSD must also be addressed.

Other Anxiety Disorders

PTSD has been included in the same category of the anxiety disorders in the *DSM-IV-TR*. Generalized anxiety disorder, or GAD, for instance, is defined by an excessive and persistent anxiety and worry during a period of at least 6 months. Some of the symptoms may include restlessness, fatigue, difficulty concentrating, irritability, muscle tension, and sleep disturbance. The *DSM-IV-TR* states that the lifetime prevalence rate of GAD is 5%.

As Resick suggests, anxiety is an associated feature of PTSD, and many anxiety disorders are actually comorbid with PTSD (as cited in Courtois & Gold, 2009). In other words, anxiety symptoms and disorders other than PTSD are also related to trauma. In a study by Maes et al., 12.6% of fire or motor vehicle accident survivors met the criteria for generalized anxiety disorder (GAD) and 10.2% met the criteria for agoraphobia (as cited in Gold, 2004). 24.6% of those with PTSD also met the criteria for GAD, and 21% of those with PTSD also met the criteria for agoraphobia. Other anxiety disorders related to

trauma exposure include panic disorder and obsessive-compulsive disorder (OCD; Courtois & Gold, 2009). For example, a study by Leskin and Sheikh (2001) suggests that trauma may act as a risk factor for concomitant panic disorder and PTSD.

Depression

According to the *DSM-IV-TR*, major depressive disorder, or MDD, is defined by either a depressed mood or loss of interest or pleasure. Some of the symptoms may include significant weight loss or gain, insomnia or hypersomnia, fatigue, feelings of worthlessness, inability to concentrate, recurrent suicidal ideation, and so on. The *DSM-IV-TR* states that the lifetime risk of MDD in women varies from 10% to 25%, and in men, 5% to 12%. In addition, PTSD comorbidity with depressive disorders is rather frequent, especially with MDD as the most concomitant disorder (Bleich et al., 1997). In fact, studies by Carey et al., McQuaid et al., and Kilpatrick et al. show that depression approaches, or even surpasses, the prevalence rates of PTSD (as cited in Bleich et al., 1997; Gold, 2004; Courtois & Gold, 2009). In studies where PTSD was found to be more prevalent than depression in the aftermath of trauma, depression rates still proved to be considerable. For example, in a study by Wenzel et al., 77% of exiled torture survivors met the criteria for either major depression or dysthymia (as cited in Gold, 2004). This is of concern as it may put an individual at further risk for suicide (Courtois & Gold, 2009).

Suicide and Suicidal Ideation

According to the *DSM-IV-TR*, as high as 15% of individuals with major depressive disorder commit suicide. Epidemiologic studies by Paykel et al., Moscicki et al., Kessler et al., and Dube et al. estimate that 1.1% to 4.6% of the population attempt

suicide, 13.5% report suicidal ideation, and 3.9% have a plan (as cited in Tarrier & Gregg, 2004). Those that have experienced trauma and PTSD have an elevated risk of suicide and show more non-fatal suicidal behavioral and ideation than those without PTSD (Tarrier & Gregg, 2004; Krysinska & Lester, 2010). Furthermore, in a study by Davidson and colleagues, it was found that 19.8% of a PTSD sample had attempted suicide compared to 3.9% of those with other psychological disorders (as cited in Tarrier & Gregg, 2004). In addition, even those with subthreshold PTSD (i.e., those that do not meet full criteria for PTSD) are at higher risk for suicidal ideation, even surpassing those with panic disorders and social phobias (Marshall, Olfson, Hellman, Blanco, Guardino, & Struening, 2001). Thus, suicidal ideation and attempt is a serious problem for those with subthreshold PTSD, and is not limited to major depressive disorder (Marshall et al., 2001). However, PTSD comorbidity can also contribute to suicidality after trauma, manifesting itself as depression, anxiety, and substance abuse (Tarrier & Gregg, 2004). For example, suicidal ideation was the most severe in individuals with concomitant PTSD and depression (Oquendo, Friend, Halberstam, Brodsky, Burke, Grunebaum, Malone, & Mann, 2003). In fact, suicidal ideation decreases in major depressive episodes as PTSD subsides. Other studies by Hopes and Williams; Iancu et al.; and Ponizovsky and Ritsner show that there is a relationship between suicide with depression, hostility, and anxiety (as cited in Ben-Ya'acov & Amir, 2004).

Substance Abuse

Studies have shown that individuals seeking treatment for PTSD are more likely to meet the criteria for substance abuse or dependence (Gulliver & Steffen, 2010). In fact, up to 60% of individuals seeking treatment for substance use disorder (SUD) present with

PTSD (Brady, Dansky, Sonne, & Saladin, 1998). In more recent studies by Ouimette et al. and Read et al., approximately 40% of patients in substance abuse treatment met the criteria for co-occurring PTSD, and have more severe PTSD symptoms than those with just PTSD (as cited in Ray, Capone, Sheets, Young, Chelminski, & Zimmerman, 2009). The literature indicates that there is a strong relationship between SUD and PTSD, with a lifetime prevalence rate ranging from 12% to 58% (Back, Dansky, Coffey, Saladin, Sonne, & Brady, 2000).

Specifically, those with PTSD are at a significantly higher risk for alcohol-related problems compared to those exposed to trauma without the development of PTSD and those who have never been exposed to trauma (Stewart, 1996). According to the U.S. National Comorbidity Survey, the prevalence rate of comorbid PTSD and lifetime alcohol dependence is 10.3% for men and 26.2% for women (as cited in McCarthy & Petrakis, 2010). However, "harder" substances, such as cocaine and opioids, show higher comorbidity with trauma and PTSD than other substances, such as alcohol and marijuana (Najavitz, Gastfriend, Barber, Reif, Muenz, Blaine, Franke, Crits-Christoph, Thase, & Weiss, 1998). For example, 29% of opioid-dependent drug abusers met the criteria for PTSD in a study by Clark et al. (as cited in Gold, 2004).

Comorbidity of substance use and PTSD is of concern as it is associated with higher rates of psychosocial problems, medical problems, hospitalizations, less social support, and more unemployment (McCarthy & Petrakis, 2010; Jacobsen, Southwick, & Kosten, 2001; Ouimette, Finney, & Moos, 1999). More alarming is the fact that there is a high prevalence rate of depressive symptoms and higher rate of suicidal thoughts and suicide attempts associated with substance use (Clark, Masson, Delucchi, Hall, & Sees,

2001; Leeies, Pagura, Sareen, & Bolton, 2010).

Physical Health Problems

In addition to mental health problems, it is rather common for individuals to develop concomitant physical health problems as a result of trauma (Asmundson, Coons, Taylor, & Katz, 2002). In fact, trauma survivors often have significant physical health problems that are long-lasting and are beyond the effects of a direct physical injury (Kendall-Tackett, 2009). Individuals exposed to trauma have adverse physical health outcomes, including an increase in physical symptoms, poor self-reported health status, increase in self-reported medical problems, overall pain ratings, pain-related disability, medical morbidity and mortality, greater utilization of medical services, and greater health care costs (Schnurr & Green, 2004; Engelhard, van den Hout, Weerts, Hox, & van Doornen, 2009; Kinder, Bradley, Katon, Ludman, McDonell, & Bryson, 2008; Gill, Szanton, Taylor, Page, & Campbell, 2009; Asmundson et al., 2002; Polusny, Ries, Schultz, Calhoun, Clemensen, & Johnsen, 2008). Some additional medical conditions associated with PTSD is chronic pain, back pain, swollen joints, hypertension, coronary artery disease, thyroid disorder, cancer, cardiovascular diseases, respiratory diseases, gastrointestinal diseases, diabetes, lung disease, cardiac heart failure, myocardial infarction, pneumonia, stroke, and so on (Asmundson et al., 2002; Gill et al., 2009; Sareen, Cox, Stein, Afifi, Fleet, & Asmundson, 2007; Kinder et al., 2008).

Individuals with depression also experience a range of medical comorbidities that are similar to those that experience PTSD, such as cancer, lung disease, pneumonia, stroke, cardiac heart failure, and myocardial infarction (Kinder et al., 2008). Other studies indicate a link with depression and coronary heart disease, osteoporosis, and reduced

rehabilitation efficacy for a variety of diseases (Kiecolt-Glaser, McGuire, Robles, & Glaser, 2002). Anxiety can also have adverse effects, specifically, coronary heart disease, recurrent ischemic events, and death (Kiecolt-Glaser et al., 2002).

In addition, distressed individuals experiencing depression and PTSD are more likely to engage in deleterious health behaviors and habits, such as smoking, alcohol and substance use, poor sleep, and non-adherence to exercise, dietary, and medical regimens (Kinder et al., 2008; Kiecolt-Glaser et al., 2002). Unfortunately, these health behaviors can have a greater risk for cardiovascular, immunological, and endocrinological consequences (Kiecolt-Glaser et al., 2002).

Need for Intervention and Psychological First Aid

Individuals and organizations involved in disaster relief, local aid work, and international aid work may be unaware of the effects of trauma and the temporary disruptions in normal functioning that can give way to psychopathology, such as posttraumatic stress disorder, depression, and anxiety. This is of concern as they come in contact with individuals who have experienced traumatic situations. Thus, training in some of the basics of psychological first aid must be implemented.

The National Child Traumatic Stress Network and the National Center for PTSD collaborated together using consultations from disaster response professionals and created a "Psychological First Aid" (PFA) Field Operations Guide (Ruzek et al., 2007). The PFA has attempted to draw from research evidence, is tailored to be applicable in field settings, covers the full developmental range, and is culturally sensitive. Although it hasn't been systematically studied, it appears to be promising in aiding trauma survivors. PFA has also been described as either a clinical intervention or a set of activities that can

be carried out by non-clinicians (Reyes & Jacobs, 2006). Despite this confusion of its description, PFA can be a helpful tool in providing relief for the individual suffering from a traumatic event. This guide, then, can be a valuable asset to training volunteers and workers to be familiar with the basics of providing psychological relief.

Ruzek et al. outlines the core actions of PFA as follows: a) contact and engagement; b) safety and comfort; c) stabilization; d) information gathering: current needs and concerns; e) practical assistance; f) connection with social supports; g) information on coping support; and h) linkage with collaborative services. However, even before these courses of actions are taken, Ruzek et al. stresses the importance of entering the scene of the incident in a calm and collected manner. The PFA provider should learn as much as possible about the setting, available services/resources, policies/procedures of organization, the nature of the event, etc. Then s/he should identify the individuals that are especially showing signs of acute psychological distress (e.g., extremely withdrawn, confused, angry, impulsive, inappropriate affect, etc.). In addition, individuals at special risk must also be identified: children, those with physical disabilities, those with severe mental illness, mothers with infants, pregnant mothers, and those who experienced the trauma first-hand.

Ruzek et al. then proceeds in describing the various courses of action. The first of which is to establish contact and engagement. The PFA providers will need to develop a positive relationship from the start and know when and how to initiate contact with the individuals, especially as some may not need or want help. In addition, physical safety should immediately be ensured and emotional comfort must also be provided. Physical safety includes seeking assistance from a medical and/or security team in the case that

someone is expressing anger towards self or others, being alert to medical concerns, and protection from violations of privacy or re-traumatizing information via media. If necessary, stabilization may be used to calm individuals who are reacting in such a way that interferes with their comprehension of the situation (e.g., crying uncontrollably, hyperventilating, shaking, etc.). PFA providers will also need to gather information regarding current needs and whatever may be of concern (e.g., need for immediate referral, additional services, etc.). Providers must be sensitive in knowing what information to gather and to what extent. Practical help must be offered to survivors in terms of addressing immediate needs and concerns. An important PFA action is providing assistance for re-establishing connection with support persons (e.g., family members, friends, etc.). Although providers do not provide treatment to psychological problems, it is part of their role to provide brief psychoeducation in terms of coping, stress reactions, and the traumatic event itself. The providers must use their critical judgment in deciding when to present the information that is most pertinent to the survivor. Lastly, PFA providers serve as the link to additional services if the survivor wants them.

As was mentioned earlier, PFA has not been systematically studied, however it is tailored for field settings, covers the developmental range, and is culturally sensitive. Thus, it can be used as an effective tool in providing aid for disaster survivors. It is important to be aware of the resiliency of people, as well as the psychopathology that can be a result from trauma. Being aware of resiliency also elucidates understanding that recovery is a restoration towards normalcy. Having this awareness, then, allows one to differentiate between normal reactions to traumatic stress and the more negative

psychopathological reactions associated with PTSD, anxiety disorders, depression, and so on.

Target Audience

This manual will be targeting the individual intending to assist in disaster relief or aid work, both local and international. Not only will educating these individuals be advantageous to the trauma survivors that they will encounter, but it will also be of benefit to themselves. The research literature on the psychological health problems on rescue workers is not as thorough as that of the victims. However, workers and volunteers of disaster relief can experience psychological problems. They can experience secondary traumatic stress (STS) and vicarious traumatization (VT), which is "an acute stress reaction to a traumatic event experience indirectly" (Phipps & Byrne, 2003).

For example, traumatic stress is reported by 80.1% of those on the mission field (Irvine, Armentrout, & Miner, 2006). According to Irvine et al. (2006), the most common forms of traumatic stress were personal crises and failure of the missionary's support systems. Like Bolton et al. suggested, psychopathology increases poor psychosocial functioning, and in light of Irvine et al.'s results, it seems likely that trauma and social support may influence one another. And as Barnett, Duvall, Edwards, and Hall (2005) claim, the quality of the missionary's relationship with others (especially with peers and authority figures) and God can determine their effectiveness in working in a cross-cultural setting. Irvine et al. go on to mention possible factors as postulated by Miersma (1993) that may contribute to the stress levels of missionaries. For example, not being able to debrief, discuss, and decompress, lack of support, and unexpected crises are among the suggested factors.

In addition to secondary traumatic stress and vicarious traumatization, physical or somatic symptoms may arise in addition to psychological problems. According to Leitch, Vanslyke, and Allen (2009), this includes the following: loss of bowel and bladder control, increased heart rate, myofascial pain, diabetes, heart disease, and other stress-related diseases.

Both victims of disaster and rescue workers may face traumatic stress as well as physical and somatic symptoms. However, with the help of this manual, missionaries will hopefully feel adequately prepared in the face of unexpected crises and be reassured in the knowledge that they are not alone in the emotional turmoil that they themselves may be experiencing. As important as it is for survivors of trauma to be assisted, it is also crucial to ameliorate traumatic stress levels of those that are aiding them by having the preventative measures of psychoeducation.

CHAPTER 3

INTRODUCTION TO DISASTERS

Key Concepts to Know about Disasters

Disasters are events that can be traumatic, cause great damage or loss of life, and also greatly outweigh the coping ability of the impacted community. Unfortunately, they are not rare and often result in a devastating outcome for individuals and communities. Although disasters vary greatly from one another and have different characteristics, there are several underlying principles important to understanding disasters and the mental health services that must accompany them. The following is a list of key concepts of disasters that should be kept in mind by any one involved in disaster relief (Myers, 1994). It was compiled through the use of research and firsthand experience of mental health administrators and practitioners involved in disaster recovery services.

- No one who sees a disaster is untouched by it.
- There are two types of disaster trauma – individual and community.
- Most people pull together and function during and after a disaster, but their effectiveness is diminished.
- Disaster stress and grief reactions are normal responses to an abnormal situation.
- Many emotional reactions of disaster survivors stem from problems of living brought about by the disaster.
- Most people do not see themselves as needing mental health services following disaster and will not seek such services.
- Survivors may reject disaster assistance of all types.
- Disaster mental health assistance is often more “practical” than psychological in nature.
- Disaster mental health services must be uniquely tailored to the communities they serve.
- Mental health workers need to set aside traditional methods, avoid the use of mental health labels, and use an active outreach approach to intervene successfully in disaster.
- Survivors respond to active interest and concern.
- Interventions must be appropriate to the phase of the disaster.
- Social support systems are crucial to recovery.

Survivors of disasters tend to be normal, well-functioning people who are temporarily struggling with the disruption brought about by the disaster. Fortunately, a vast majority of individuals have the resilience needed to cope with such traumatic events with little to no disruption in their overall psychosocial functioning (Bonanno, 2004; Masten, 2001). However, all experience distress and some others may go through a period of psychopathology. As a result, individuals involved in disaster relief and aid work must be proactive in reaching out to survivors because many may not view themselves as needing mental health services. Thus, these concepts illustrate the uniqueness of disaster mental health services that differ from more traditional mental health services.

Characteristics of Disasters

Disasters are not uniform; they have different elements and characteristics, and can be classified in a variety of ways. The main disaster classifications that will be used are *natural* versus *human-made disasters* (also known as *industrial*, *technological*, *complex emergencies*, and so on). Some other disaster characteristics are: the degree of personal impact, size and scope, visible impact/low point, and the probability of recurrence (DeWolfe, 2000).

Natural versus Human Causation

Natural disasters have diverse characteristics and can vary in any number of variables. For example, the onset and duration of a flood is very different from that of a drought. Thus, the onset and duration can be rapid or slow. In addition, the severity of the disaster can vary greatly even within the same type (i.e., a 6.2-magnitude earthquake

versus an 8.9-magnitude earthquake), and early warning signs can vary as well. Natural disasters include tornados, hurricanes, droughts, earthquakes, forest fires, and volcanic eruptions (refer to Table 1 for natural disaster classifications).

Table 1
Disaster Classifications

	Natural	Human-Made
Earth	Avalanches	Ecological irresponsibility
	Earthquakes	Road and train accidents
	Erosions	Ecological neglect
	Eruptions	Outerspace debris fallout
	Toxic mineral deposits	Radioactive pollution
		Toxic waste disposal
Air	Blizzards	Aircraft accidents
	Cyclones	Hijackings
	Dust storms	Spacecraft accidents
	Hurricanes	Acid rain
	Meteorites/Planetary activity	Radioactive cloud and soot
	Thermal shifts	Urban smog
	Tornadoes	
Fire	Bushfires	Fire-setting
	Lightning	
Water	Drought	Maritime accidents
	Floods	
	Storms	
	Tsunamis	
People	Endemic disease	Civil strife
	Epidemics	Criminal extortion by chemical and biological contaminants
	Famine	Guerrilla warfare
	Overpopulation	Hostage-taking
	Plague	Plant accidents
		Sports crowd violence
		Terrorism
		Torture

Adapted from NSW Health (2000)

In contrast to natural disasters, human-made disasters are caused by human accidents or human violence, such as war or terrorism. As such, there usually is no

warning, producing shock and loss of control (NSW Health, 2000). Examples of human-made disasters include explosions, structure collapses, war, and terrorism (refer to Table 1 for human-made disasters).

Degree of Personal Impact

The degree of personal exposure to the disaster increases the survivor's post-disaster reactions, such as anxiety, depression, and so on. Examples of high impact would be the death of a loved one, destruction of one's neighborhood, and loss of personal possessions.

Size and Scope

Similar to the degree of personal impact, the degree of the community destruction also increases the survivor's post-disaster reactions. When the whole community is destroyed, everything familiar is lost, leaving survivors confused and disoriented. It is easier for communities to adjust to life pre-disaster if some aspects of their familiar community life are intact (e.g., schools, markets, churches, etc.).

Visible Impact/Low Point

Fortunately, most disasters, particularly natural disasters, have a visible impact that has a clear end point, which signifies the beginnings of recovery period. In the case of hurricanes or wildfires, survivors see the extent of the destruction and can then move forward in the recovery and healing process. Other natural disasters, such as earthquakes, the aftershocks may have survivors worrying that a bigger earthquake is around the corner. In certain human-made disasters, such as nuclear accidents, there is no visible impact or an observable "low point." As NSW Health (2000) points out, the health

consequences of cancer and birth defects can continue long after the disaster, further prolonging the recovery and healing process.

Probability of Recurrence

When disasters are seasonal, such as hurricanes, survivors worry about a second appearance before the season is over. In addition, their stress reactions may rise again during the one-year anniversary. For some disasters, such as earthquakes, the probability of recurrence can be immediate due to the aftershocks.

Phases of Disaster

Despite the variability of disasters, the responses tend to progress in a rather predictable pattern of phases (see Figure 1). The phases of disaster by Myers, Zunin, and Zunin (1990) are composed of: the warning or threat phase, impact phase, rescue or heroic phase, remedy or honeymoon phase, inventory phase, disillusionment phase, and the reconstruction or recovery phase (DeWolfe, 2007). These phases of disaster are especially important for the aid worker to be aware of in order to accurately assess and assist survivors appropriately.

Warning or Threat Phase

The amount of warning signs varies from disaster to disaster. For example, earthquakes and tornadoes typically do not give off any warning. Hurricanes, on the other hand, show warning signs within hours or up to a couple of days. Furthermore, volcanoes erupt after weeks or months of warning signs.

In instances where there is no warning for a disaster, survivors may feel unsafe, anxious, confused, fearful of future tragedies, and that they have no control. They may

feel incapable of protecting themselves, their loves ones, and their homes. In contrast, those that didn't respond to warning signs may feel responsible for the incurring damage and may experience guilt and self-blame.

Impact Phase

Similarly to the warning/threat phase, the impact period differs depending on the disaster itself. It can vary from a slow, gradual, low-threat buildup (e.g., droughts and floods) to a sudden, violent, high-threat outcome (e.g., explosions and tornadoes). Survivors may feel shocked, paralyzed, powerless, and disorganized.

Rescue or Heroic Phase

Immediately after the impact phase, in the aftermath, a high level of energy and adrenaline is used for survival, rescuing, finding shelter, repairing, and cleaning damage. This activity tends to last anywhere from a few hours to several days. When survivors are faced with separations from their family due to evacuations, shelter restrictions, or other factors, post-traumatic reactions can ensue. In addition, altruism is high among survivors and aid workers.

Remedy or Honeymoon Phase

Due to the influx of assistance and resources from the government and volunteer workers, community bonding and survivor optimism is high. Spontaneous groups develop as survivors share the experience of the disaster with one another. Survivors become very hopeful and believe that their lives and community will recover and restore to its original form quickly. Aid workers and disaster mental health workers during this phase are more easily accepted when they are visible and perceived as helpful. This phase

is especially crucial in establishing rapport and a foundation in which to assist more effectively in the following difficult phases.

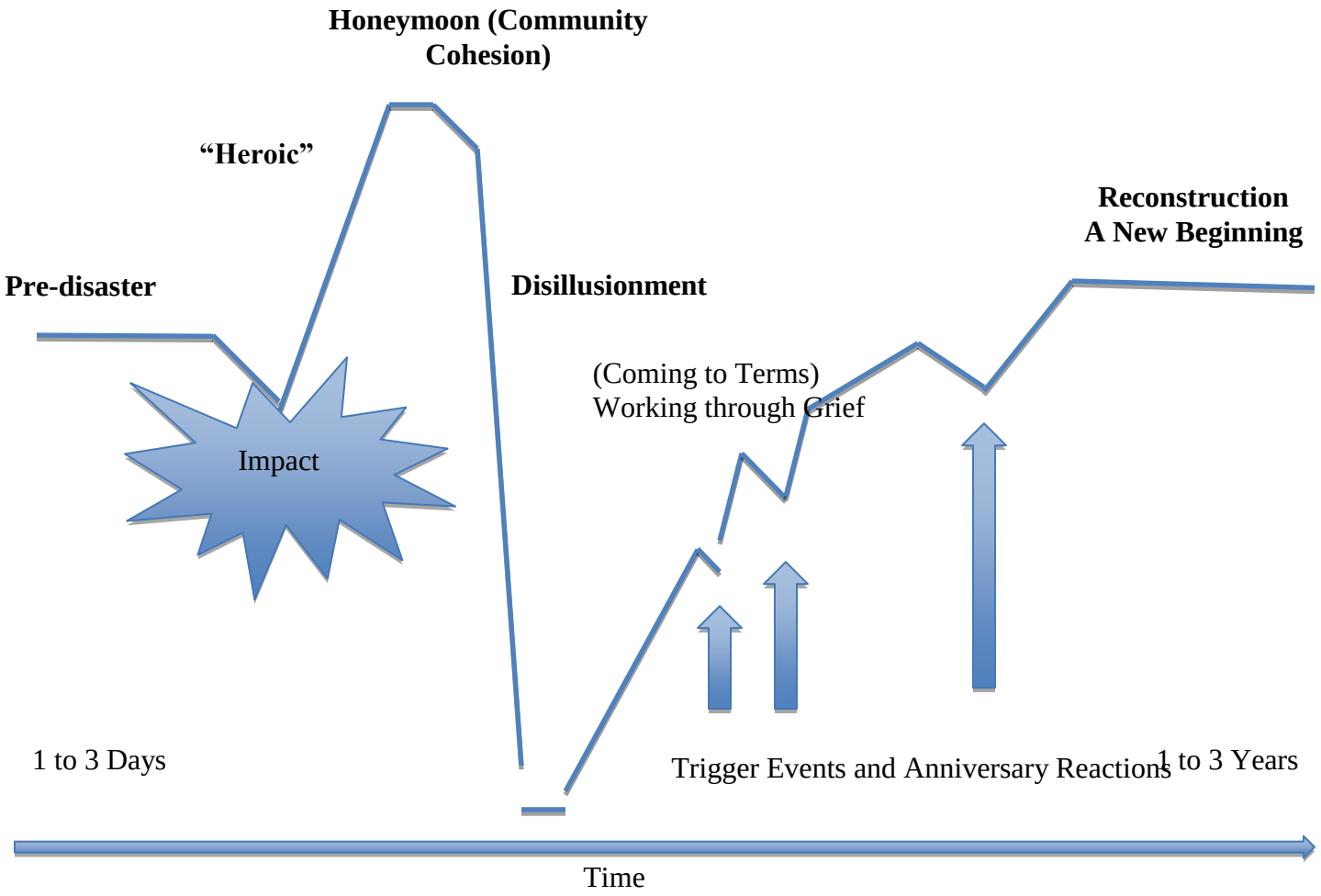

Figure 1. Phases of disaster (adapted from Myers, Zunin, & Zunin, 1990)

Inventory Phase

Over time, however, survivors begin to realize the limits of the available resources. The hope that their homes and lives will quickly be restored and without complications becomes replaced with physical exhaustion. Survivors become fatigued and discouraged by the enormous demands, financial situations, rebuilding, and restoration. This quickly leads to the next phase of disillusionment.

Disillusionment Phase

As fatigue and the recognition of all that needs to be done for restoration sets in, disillusionment begins. The reality of finances, losses, politics, relocation, and available assistance become unavoidable. In addition, feelings of abandonment, resentment, and injustice may arise as government assistance and volunteers pull out. At this time as well, the community cohesion that formed in the remedy/honeymoon phase may start to rupture as seemingly unequal monetary compensations build resentment and hostility.

Reconstruction or Recovery Phase

In this phase, survivors start to realize that they are the ones to be responsible for rebuilding their homes and lives. By this time as well, observable changes become apparent as reconstruction takes place. The majority of individuals are able to resume their previous level of functioning even after a temporary period of distress. Often, however, survivors need to readjust as their community is rebuilt and as they are faced with various triggers, such as the anniversary.

CHAPTER 4

REACTIONS TO DISASTERS

Stress Reactions and Model

The majority of survivors are affected by a disaster, but fortunately, most have the resilience necessary to recover with little or no disruption in their psychosocial functioning (Bonanno, 2004; Masten, 2001). However, it is quite common for most to show some signs of distress "as an immediate or acute-phase reaction" (NSW Health, 2000). Typically, reactions are transient and are a normal response to a shocking and traumatic event. It is important for aid workers to reassure survivors of the normalcy of their stress reactions.

Disasters are not only a psychosocial stress as it often also affects the physical and spiritual as well. Using a biopsychosocial-spiritual model is important in identifying the stress symptoms and reactions of the survivor (see Figure 2). By using this model, a more holistic approach can be taken in assessing and assisting.

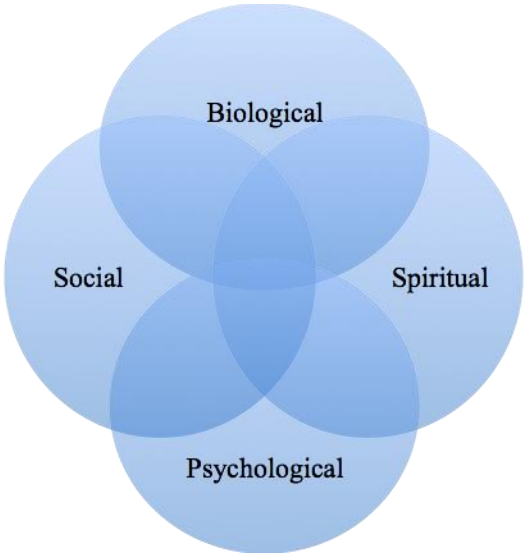

Figure 2. Biopsychosocial-spiritual model for recovery

Although a good number of disaster relief manuals do not incorporate the spiritual component, many survivors may find comfort and hope in a higher power, or have their spiritual beliefs shaken by perceived abandonment. In addition, as Connor, Davidson, and Lee (2003) state, spirituality may further enhance one's coping ability for some; while for others, negative events may result in strengthening of religious faith. However, with that said, religious faith and spirituality may not apply to all survivors. The aid worker must be sensitive and respectful of the survivor's spiritual beliefs or lack thereof. In addition to the personal religious faith, culture must also be taken into consideration as an influence on the individual's spirituality. There could also be cultural rituals related to grief (NSW Health, 2000). In addition, "culture has a profound influence on each individual's experiences and perceived reality," and therefore must not be ignored in disaster relief (Comas-Diaz, L., Griffith, E.H., Pinderhughes, E.G., & Wyche, K.F., 1995).

So saying, survivors experience the emotional impact of the disaster in a variety of ways that manifests itself as biological, psychological, social, and possibly spiritual. Table 2 is a compilation of the common stress reactions that survivors may experience, consisting of physical/biological, cognitive, emotional, behavioral, social, and spiritual.

Table 2
Common Stress Reactions

Physical/Biological	Cognitive	Emotional
Body tensions	Mental confusion	Fear or terror
Fatigue and exhaustion	Amnesia (problems remembering aspects of the disaster)	Helplessness and loss of control
Low back pain	Concentration problems	Anger or irritability
Increased levels of cortical and norepinephrine	Attention problems	Despair
	Flashbacks and intrusive thoughts	Shock
Elevated blood pressure	Denial	Anxiety
Cardiovascular reactivity and "racing heart"	Decreased decision-making capacity	Shame
	Nightmares	Survivor's guilt
		Resentment

Muscle cramps	Dissociation	Depression
Respiratory problems	Mental disorientation and disorganization	Grief or sadness
Disorder of sexual desire (decreased or increased libido)	Obsessions with death	Revenge motivation
Body injuries, aches, and pain	Distorted sense of time	Dramatic mood changes (ups/downs)
Somatic complaints	Decreased self-esteem	Phobia
Fainting	Decreased self-efficacy	Emotional numbing
Increased startle response	Slowed thinking	Feelings of insignificance
Nausea and/or vomiting	Difficulty identifying people or objects	Loss of pleasure from regular activities
Upset stomach	Hypervigilance	Distrust
Gastrointestinal problems		Feeling lost
Headaches		Apathy
Rapid breathing		Paranoia
Profuse sweating		Cynicism
Loss of coordination		Negativity
Dizziness		Problem controlling emotions
Behavioral	Social	Spiritual
Impairment in school/work	Social withdrawal	Loss of hope or faith
Running away	Alienation and isolation	Questioning of spiritual faith
Hiding	Difficulty giving/accepting support or help	Feelings of abandonment
Angry outbursts	Blaming	Strengthened spiritual faith
Acting out	Intimacy avoidance	Leaving ties to a community of faith
Hyperactivity	Over-protectiveness toward loved ones	Development of spiritual faith that wasn't previously explored
Hypoactivity	Increased interpersonal conflicts	Withdrawal from place of worship
Pacing or erratic movement	Increased affiliating behaviors	Uncharacteristic spiritual involvement
Loss or increased appetite		Sense of isolation from higher power and religious community
Increased alcohol or substance use		Belief that higher power is not in
Insomnia		
Restlessness		

	control Belief that higher power does not care Faith is challenged or rejected

Adapted from DSM-IV-TR (2000); NSW Health (2000); Gheith, A. (2007)

Mental Health Outcomes

The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* is used by "psychiatrists, other physicians, psychologists, social workers, nurses, occupational and rehabilitation therapists, counselors, and other health and mental health professionals" *(DSM-IV-TR*; American Psychiatric Association, 2000). The following are the diagnostic criteria for each of the disorders or disturbances that can happen as a result of a traumatic event.

Acute Stress Disorder

- The person has been exposed to a traumatic event in which both of the following were present:
  - The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
  - The person's response involved intense fear, helplessness, or horror.
- Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following dissociative symptoms:
  - A subjective sense of numbing, detachment, or absence of emotional responsiveness.
  - A reduction in awareness of his or her surroundings (e.g., "being in a daze").
  - Derealization.
  - Depersonalization.
  - Dissociative amnesia (i.e., inability to recall an important aspect of the trauma).
- The traumatic event is persistently reexperienced in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback

episodes, or a sense of reliving the experience; or distress on exposure to reminders of the traumatic event.

- Marked avoidance of stimuli that arouse recollections of the trauma (e.g., thoughts, feelings, conversations, activities, places, people).
- Marked symptoms of anxiety or increased arousal (e.g., difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, motor restlessness).
- The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or impairs the individual's ability to pursue some necessary task, such as obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience.
- The disturbance lasts for a minimum of 2 days and a maximum of 4 weeks and occurs within 4 weeks of the traumatic event.
- The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition, is not better accounted for by Brief Psychotic Disorder, and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.

Posttraumatic Stress Disorder

- The person has been exposed to a traumatic event in which both of the following were present:
    - The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
    - The person's response involved intense fear, helplessness, or horror. *Note:* In children, this may be expressed instead by disorganized or agitated behavior.
- The traumatic event is persistently reexperienced in one (or more) of the following ways:
    - Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. *Note:* In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
    - Recurrent distressing dreams of the event. *Note:* In children, there may be frightening dreams without recognizable content.
    - Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). *Note:* In young children, trauma-specific reenactment may occur.
    - Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

    - Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
- Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
    - Efforts to avoid thoughts, feelings, or conversations, associated with the trauma.
    - Efforts to avoid activities, places, or people that arouse recollections of the trauma.
    - Inability to recall an important aspect of the trauma.
    - Markedly diminished interest or participation in significant activities.
    - Feeling of detachment or estrangement from others.
    - Restricted range of affect (e.g., unable to have loving feelings).
    - Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).
- Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
    - Difficulty falling or staying asleep.
    - Irritability or outbursts of anger.
    - Difficulty concentrating.
    - Hypervigilance.
    - Exaggerated startle response.
- Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.
- The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- Specify if:
    - *Acute*: if duration of symptoms is less than 3 months
    - *Chronic*: if duration of symptoms is 3 months or more
- Specify if:
    - *With Delayed Onset*: if onset of symptoms is at least 6 months after the stressor

Major Depression

- Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
    - Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). *Note:* In children and adolescents, can be irritable mood.

- Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).
- Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. *Note:* In children, consider failure to make expected weight gains.
- Insomnia or hypersomnia nearly every day.
- Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
- Fatigue or loss of energy nearly every day.
- Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
- Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

Substance Abuse

- A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:
  - Recurrent substance use resulting in a failure to fulfill major role obligations at work, school., or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household).
  - Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use).
  - Recurrent substance-related legal problems (e.g., arrest for substance-related disorderly conduct).
  - Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights).
- The symptoms have never met the criteria for Substance Dependence for this class of substance.

Age Groups and Vulnerable Populations

Although disasters are devastating to all who are a part of it, there are certain individuals that are even more at risk (Brymer, M., Jacobs, A., Layne, C., Pynoos, R., Ruzek, J., Steinberg, A., Vernberg, E., & Watson, P., 2006), which includes:

- Children, especially those:
  - Separated from parents/caregivers
  - Whose parents/caregivers, family members, or friends have died
  - Whose parents/caregivers were significantly injured or are missing
  - Involved in the foster care system
- Those who have been injured
- Those who have had multiple relocations and displacements
- Medically frail children and adults
- Those with serious mental illness
- Those with physical disability, illness, or sensory deficit
- Adolescents who may be risk-takers
- Adolescents and adults with substance abuse problems
- Pregnant women
- Mothers with babies and small children
- Disaster response personnel
- Those with significant loss of possessions
- Those exposed first hand to grotesque scenes or extreme life threat

In addition to these vulnerable populations, each stage of life is also accompanied by special challenges (see Table 3; DeWolfe, 2000).

Table 3
Reactions According to Age Groups

Age Groups	Behavioral Symptoms	Physical Symptoms	Emotional Symptoms
Preschool (ages 1-5)	Clings to parents Resumption of bed-wetting, thumb-sucking Fears dark Avoidance of sleeping alone Increased crying	Loss of appetite Stomachaches Nausea Sleep problems and/or nightmares Speech difficulties Tics	Anger outbursts Anxiety Fear Irritability Sadness Withdrawal
Childhood (ages 6-11)	Poor academic performance Aggressive behavior at home or school	Changes in appetite Headaches Sleep problems and/or nightmares	School avoidance Withdrawal from friends Anger outbursts

	Hyperactive or silly behavior Whining, clinging, acting like a younger child Increased competition with younger siblings for attention	Stomachaches	Obsessive preoccupation with disaster and safety Withdrawal from friends and familiar activities
Pre-adolescence and Adolescence (ages 12-18)	Poor academic performance Rebellion at home or school Decline in previous responsible behavior Agitation Decrease in energy level Apathy Delinquent behavior Social withdrawal	Appetite changes Headaches Gastrointestinal problems Skin eruptions Complaints of aches and pains Sleep disorders	Loss of interest in peer social activities, hobbies, recreation Depression or sadness Resistance to authority Feelings of inadequacy and helplessness
Adults	Sleep problems Avoidance of reminders Excessive activity Crying easily Increased interpersonal conflicts Hypervigilance Social isolation Withdrawal	Fatigue and exhaustion Gastrointestinal problems Appetite changes Somatization symptoms Worsening of chronic conditions	Depression and sadness Irritability and anger Anxiety Fear Despair and hopelessness Guilt Self doubt Mood swings
Older Adults	Withdrawal Social isolation Reluctance to leave home Limitations in mobility Relocation adjustment problems	Worsening of chronic conditions Sleep disorders Memory problems Somatization symptoms Susceptibility to hypo- and hyperthermia Physical and sensory limitations interfere with recovery	Depression Despair Apathy Confusion Disorientation Suspicion Agitation Anger Fears of institutionalization Anxiety with unfamiliar surroundings Embarrassment about receiving “hand outs”

Adapted from DeWolfe, D. (2000)

CHAPTER 5

PSYCHOLOGICAL FIRST AID

Introduction to Psychological First Aid

The National Child Traumatic Stress Network (NCTSTN) and the National Center for PTSD collaborated together to create Psychological First Aid (PFA), an "evidence-informed modular approach" designed to assist children, adolescents, parents/caretakers, adults, and families in the aftermath of disasters and terrorism (Brymer, M., Jacobs, A., Layne, C., Pynoos, R., Ruzek, J., Steinberg, A., Vernberg, E., & Watson, P., 2006). In addition, PFA can be used for first responders and other disaster relief aid workers. The principles and techniques are based on the following standards: a) consistent with research evidence on risk and resilience following trauma; b) applicable and practical in field settings; c) appropriate for developmental levels across the lifespan; d) culturally informed and delivered in a flexible manner. In addition to these standards, PFA is composed of eight core actions: a) contact and engagement; b) safety and comfort; c) stabilization; d) information gathering: current needs and concerns; e) practical assistance; f) connection with social supports; g) information on coping; h) linkage with collaborative services.

Contact and Engagement

The goal of this core action is to respond to contacts made by survivors, or to initiate contacts in a non-intrusive, compassionate, and helpful manner. Key points for this section include:

- The first contact with a survivor is especially important in establishing rapport and setting the groundwork for increasing his/her receptiveness to further help
- Be respectful, compassionate, and calm
- Culture alert: be familiar with the culture in order to know what is appropriate regarding physical or personal contact
    - For example, how close to stand to someone, how much eye contact, whether to touch or not, whether or not to talk to someone of the opposite sex
    - If unfamiliar with the culture, do not touch, approach too closely, or make prolonged eye contact
    - If working with a family, find out who the spokesperson is and address this person first
- Introduce yourself and ask about immediate needs:
    - Introduce your name, title, and describe what your role is
    - Ask if you can talk to him/her and tell them that you wanted to see if you can help
    - Give the survivor your full attention, try not to look around or be distracted, and speak softly and calmly
    - Find out if there are any pressing problems that need immediate attention, especially medical concerns
    - With children or adolescents, make contact with a parent or accompanying adult to explain your role and ask for permission to speak to the minor; if no adult is present, find a parent/caregiver as soon as possible to tell him/her about the conversation
- Confidentiality:
    - Protecting the confidentiality of survivors may be difficult in post-disaster settings, however, it is still very important
    - If you are a professional that belongs in a category of mandated reporters, you must abide by state abuse and neglect reporting laws

Safety and Comfort

The goal of this core action is to enhance safety, and provide physical and emotional comfort. Key points for this include:

- Ensure immediate physical safety:
    - Find the appropriate officials that can remove safety concerns out of your reach (e.g., weapons)
    - Remove objects that can be a safety concern (e.g., broken glass, spilled liquids, debris, etc.)
    - Make sure that children have a safe area and that they are being supervised

    - Make sure that a particular subgroup that may be persecuted based on their gender, ethnicity, religion, and so on, are safe
    - For the elderly or disabled:
        - Make the physical environment safer (e.g., adequate lighting, protection against tripping or falling)
        - Ask about the survivor's need for specific aids or devices (e.g., eyeglasses, hearing aids, wheelchairs, walkers)
        - Ask if help is needed regarding health-related issues or daily activities (e.g., eating, dressing, use of bathroom, grooming)
        - Keep a list of survivors with special needs so that they can be given extra care
        - Inquire about the need for medication
        - If available, contact relatives to further ensure safety
    - For those that require immediate medical attention:
        - Contact a medical professional immediately
        - Stay with the person or find someone to stay with the person until you can get help
    - Other safety concerns that require immediate medical support include treat of harm to self or others and shock
        - Threat of harm to self or others: intense anger towards self or others; extreme agitation (contact medical, EMT assistance, or security team)
        - Shock: pale, clammy skin; weak or rapid pulse; dizziness; irregular breathing; dull or glassy eyes; unresponsiveness to communication; lack of bladder/bowel control; restlessness, agitation, or confusion
- Provide information about disaster response activities and services:
    - Provide information about:
        - What to do next
        - What is being done for their help
        - What is currently known about the event
        - Available services to them
        - Common stress reactions
        - Self-care, family care, and coping
    - When providing information:
        - Use your judgment to determine whether you should provide the information at the time and when you should give the information
        - Address immediate needs and concerns, answer pressing questions, and support adaptive coping skills
        - Use clear and concise language, and avoid technical jargon
    - *Do not* guess or make up information if you don't have certain information,
    - *Do not* reassure survivors that they are safe unless you have definite, factual information saying that this is the case

    - *Do not* reassure or promise the availability of goods or services unless you have definite information that this is the case
    - *Do* address safety concerns based on your current understanding of the situation. The following examples are from Brymer, M., Jacobs, A., Layne, C., Pynoos, R., Ruzek, J., Steinberg, A., Vernberg, E., & Watson, P. (2006).
        - Adult/caregiver: "Mrs. Williams, I want to assure you that the authorities are responding as well as they can right now. I am not sure that the fire has been completely contained, but you and your family are not in danger here. Do you have 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 being 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:
    - Make the physical environment more comfortable (e.g., temperature, lighting, access to furniture, etc.)
    - Involve survivors in getting things needed for comfort to reduce feelings of helplessness or dependency (e.g., walk with the person to supply area)
    - For the elderly or disabled, be mindful of:
        - Physical health problems (e.g., blood pressure, fluid and electrolyte balance, respiratory issues, frailty)
        - Age-related sensory loss (e.g., visual or hearing loss)
        - Cognitive problems (e.g., attention, concentration, memory)
        - Lack of mobility
        - Unfamiliar or over-stimulating surroundings
        - Noise that can limit hearing or interfere with hearing devices
        - Limited access to bathrooms or eating areas
        - The safety of a service animal
- Promote social engagement:
    - When appropriate, facilitate group and social interactions, as it can be comforting and reassuring being near others who are coping adequately to the situation
    - However, if survivors are very agitated or overwhelmed, this can be upsetting to others
    - When appropriate, encourage survivors that are coping adequately to talk to others who are distressed – this can be helpful in reducing a sense of isolation and helplessness

    - Children, and even some adolescents, look to adults for reassurance and appropriate behavior
        - Place them next to adults who appear relatively calm and are coping adequately
    - For children, encourage social activities with one another (e.g., playing games, sports, art activity, reading out loud)
- Attend to children who are separated from their parents/caregivers:
    - Reuniting separated children to their parent/caregiver is a high priority
    - Ask the unaccompanied child for information (e.g., their name, parent/caregiver name, address, etc.) and contact the appropriate authorities
    - Provide children information about who will be looking after them and what will happen next
    - You may need to provide support, which could include setting up a child-friendly space
        - Create a child-friendly space that is safe and out of high traffic areas
        - Make sure that this area is being supervised by individuals with experience working with children of different ages
        - Monitor individuals coming and leaving the area and make sure that children do not leave with an unauthorized person
        - Stock the area with materials for all ages (e.g., crayons, toys, games, play dough, building blocks, etc.)
        - When appropriate, have older children or adolescents help as role models for the younger children (e.g., group play activities, reading, or playing)
        - Have adolescents get together to talk about their concerns and engage in age-appropriate activities (e.g., listening to music, playing games, etc.)
- Protect from additional traumatic experiences and trauma reminders:
    - Protect survivors from exposure to additional traumatic events and reminders (e.g., sights, sounds, smells)
    - Try to shield survivors from reports, media personnel, etc.
    - Encourage limited viewing of media coverage and what parents say in front of children
- Help survivors who have a missing family member:
    - Spend extra time with survivors that have a missing family member
    - If a survivor wants to leave the safe area to find a missing loved one, inform him/her about the circumstances in the area, the dangers, needed precautions, and the efforts of first responders
    - If authorities ask survivors for information regarding the missing person, limit the children's exposure to this process

    - In the case where family members have differing views on the status of the missing person (i.e., dead or alive), encourage them to be patient and respectful of each other's feelings
- Help survivors when a family member or close friend has died:
    - Culture alert:
        - Beliefs about death, funerals, and expressions of grief vary depending on culture, religious beliefs, and even families
        - Know the cultural norms with the help of the community cultural leaders
        - Do not assume that all members believe and engage in the same traditions and rituals related to the dead
    - Acute grief reactions may be intense and can include anger, guilt, regret, and a desire for reunion
        - Grief responses are normal, natural, and healthy
        - Grief reactions can start to include more positive thoughts (e.g., a positive story of a loved one)
        - Grief reactions vary and there is no "correct" way to grieve
        - Grief puts people at risk for abuse of over-the-counter medications, smoking, and alcohol
    - When working with survivors who have experienced the death of a loved one:
        - Discuss how different family members and friends will have their own reactions, that there is no right or wrong way of grieving, and that there is no "normal" period of time for grieving
        - Discuss how culture or religious beliefs influence the grieving process
        - Keep in mind that children may only show their grief for short periods of time each day and may also engage in play
        - Refer to Table 4 for a list of things to say or don't say to grieving individuals

Table 4
Do and Don't…

Do	Don't Say
Reassure individuals that their grief is understandable and expectable	I know how you feel
Use the deceased person's name, instead of saying, "the deceased"	It was probably for the best
Tell them that they will most likely experience periods of sadness, loneliness, or anger	S/he is better off now
Tell them that if they experience grief or depression that affects functioning, talking to a clergy member or	It was his/her time to go
	At least s/he went quickly
	Let's talk about something else
	You should work towards getting over this
	You are strong enough to deal with this
	That which doesn't kill us makes us stronger

counselor	You'll feel better soon
Tell them that the doctor, department of mental health, or hospital can refer them to the appropriate services	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/father
	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

Adapted from the Brymer, M., Jacobs, A., Layne, C., Pynoos, R., Ruzek, J., Steinberg, A., Vernberg, E., & Watson, P. (2006)

- Child and adolescent understanding of death:
  - Pre-school children: they may not believe that death is permanent and may believe that the person will return if they wish for it; they need help realizing that the deceased person is no longer breathing, moving, having feelings, or in pain; they may be worried that something bad will happen to another family member
  - School-age children: they may understand the physical reality of death, but may personify death as a monster or skeleton; they may experience the "ghostlike" presence of the deceased person
  - Adolescents: they understand that death is irreversible; they can become angry and impulsive (quitting school, running away, using substances)
- Child and adolescent are affected differently by death depending on age:
  - Pre-school children: they need consistent care, predictable routines, and structure; they can get easily upset; they should be asked if they are doing something differently or something "wrong" (e.g., "Am I not doing this the way Mommy did?")
  - School-age children: other caregivers should assume the role of comfort and help with daily activities; children may be angry at the caregiver, especially when disciplined; caregiver should acknowledge that the child misses the deceased caregiver and provide extra comfort
  - Adolescents: they may experience a sense of unfairness and protest over the death; they may need to take on greater

responsibilities and resent not being able to have a normal life; over time, caregivers should talk about how to balance these needs

- Suggestions for talking to children and adolescents:
  - Assure children that they are loved and will be taken care of
  - Watch for signs that the child may be ready to talk about what happened
  - Do not make the child feel guilty or embarrassed for wanting or not wanting to talk
  - Do not push children to talk
  - Give short, simple, honest, and age-appropriate answers
  - Listen to their feelings without judgment
  - Reassure them that they didn't cause the death, it wasn't their fault, and that it was not punishment for something they did "wrong"
  - Answer honestly about funerals, burials, and so on
  - Be prepared to answer the child's questions again and again
  - Do not be afraid to say that you don't have an answer

- Attend to grief and spiritual issues:
  - Be familiar with clergy if they are part of the disaster response team or how to contact local religious groups for referral purposes
  - It is common for people to rely on spiritual beliefs and practices for coping purposes
  - It is not necessary for you to share the same religious beliefs in order to be supportive
  - Not everyone may even have religious beliefs, but you can introduce the topic by asking, "Do you have any religious or spiritual needs at this time?" (Brymer, M., Jacobs, A., Layne, C., Pynoos, R., Ruzek, J., Steinberg, A., Vernberg, E., & Watson, P., 2006) This can lead to a referral to a clergy member, rather than you engaging in spiritual counseling
  - *Do not* try to "correct" or contradict a person's spiritual beliefs, even if you disagree or believe it may be causing them distress
  - *Do not* answer spiritual questions like, "Why was this allowed to happen?" They are not real questions but typically express emotions
  - If a person is religious, ask if they would like to see a clergy member
  - People often find comfort in religious objects, such as prayer beads, sacred texts, and so on; locating objects can increase their level of security and sense of control
  - Survivors may want to pray, and you can help them find a suitable place to do so
  - If asked to join in prayer, you can decline if that feels uncomfortable

    - A survivor may voice hope for a miracle, despite seemingly impossible situations; this is not necessarily an indication that s/he has lost touch of reality; do not encourage or discourage such hope
    - Different religions have specific practices regarding death – ask survivors about their religious needs in this area
    - In some cultures, grieving practices may be really loud and unsettling – help them move to a private space so that they don't upset others
    - If a survivor expresses anger regarding his/her spiritual beliefs, do not judge or argue with him/her – most are just looking for a willing, non-judgmental listener
- Provide information about casket and funeral issues:
    - Local laws often govern the preparation of a body for burial and caskets; many jurisdictions require autopsies which can be upsetting to particular religious groups that prohibit autopsies – some jurisdictions allow autopsies to be waived by a Medical Examiner; you can help families that don't want an autopsy find out about local laws
    - Whether a child should attend a funeral, memorial service, or gravesite:
        - It can be helpful for children to attend a funeral as it helps them accept the physical reality of death; if not included, they could feel left out of something important
        - Children should be given a choice regarding attendance of a funeral or other rituals
            - Before giving children a choice, tell them what to expect, including adults being upset and crying
            - Give them an opportunity to choose who they would like to sit with during the service and make sure that this person can pay attention to them
            - Provide a way that the child can leave the service with that person, even temporarily, if they can't handle it
            - Give alternate arrangements if they don't want to attend, like staying with a neighbor or family friend
            - Offer to say/read something on their behalf if they don't want to attend; tell them that they can participate in memorial activities at a later time
        - If possible, bring younger children to the funeral location early so they can explore
        - For younger children, reinforce that the deceased person is not in any distress
- Attend to issues related to traumatic grief:
    - Some survivors may be focused on how the death could have been prevented, what the last moments were like, and who was at fault; these reactions may interfere with grieving, including:

        - Intrusive, disturbing images of death that interfere with positive remembering
        - Retreat from close relationships
        - Avoidance of usual activities because they are reminders of the traumatic death
        - For children: repetitive play that includes themes involving the traumatic death
    - Suggest talking to a mental health professional or clergy member as that can be helpful
- Support survivors who receive death notification:
    - You may be asked by police, FBI, hospital personnel, or Disaster Mortuary Operational Response Team (DMORT) members to assist family members who received a death notification
    - In some instances, news media may report that there were no survivors before official death notifications have been sent
    - Incorrect information can be circulated by the media as well: caution family members to wait for official confirmation
    - When providing support:
        - Don't rush; family members need time to process and ask questions
        - Allow for strong initial reactions as these will most likely improve over time
        - When referring to a person who is a confirmed fatality, use the word "died," not "lost" or "passed away"
        - Remember that family members want to know that you are trying to understand how *they* feel (empathy)
        - Seek assistance from medical support personnel if a medical need arises
        - Get help from authorities if survivors are at risk for hurting themselves or others
        - Make sure that social supports are available (family, friends, clergy)
        - If an unaccompanied child is told that a caregiver has died, either stay with the child or have another worker stay with the child until s/he is reunited with family members or a child protective service worker
- Support survivors involved in body identification:
    - Although you may not be involved in the body identification process, you may assist prior to and afterwards
    - In most cases, children should be discouraged from the body identification process as the body may have deteriorated or changed a lot
    - Be prepared for a wide range of reactions: "shock, numbness, fainting, vomiting, trembling, screaming, or hitting something or someone" (Brymer, M., Jacobs, A., Layne, C., Pynoos, R., Ruzek, J., Steinberg, A., Vernberg, E., & Watson, P., 2006)

- Help caregivers confirm body identification to a child or adolescent:
    - You may sit in while a caregiver tells the child or adolescent about the confirmation of the body identification
    - Allow children to ask questions
    - Caution caregivers from giving disturbing details of the physical appearance of the body

Stabilization

If stabilization is needed, the goal is to calm and orient overwhelmed or disoriented survivors. Key points for this include:

- Signs of being disoriented or overwhelmed:
    - Glassy eyed and vacant – unable to find direction
    - Unresponsiveness to verbal questions or commands
    - Disorientation
    - Strong emotional responses: uncontrollable crying, hyperventilating, rocking, or regressive behavior
    - Experiencing uncontrollable physical reactions (shaking/trembling)
    - Frantic searching behavior
    - Feeling incapacitated by worry
    - Risky activities
- Steps to stabilize distressed individuals:
    - Respect the person's privacy and give them a few minutes before intervening; tell them that you are available if they need you and/or that you will check back in a few minutes
    - Remain calm, quiet, and present, rather than talking directly to them; just remain available so that you can give them a few minutes to calm down
    - Stand close by as you talk to other survivors, do paperwork, or other tasks so that you can be available to that person if they would like further help
    - Offer support and help him/her focus on manageable feelings, thoughts, and goals
    - Give information to help orient him/her to the surroundings (e.g., how the setting is organized, what will be happening, and what steps s/he may consider)
- To help overwhelmed survivors understand how they're feeling, you can use Table 5 for ideas of what could be said

Table 5
Sample Explanations of Emotions

Children and Adolescents	Adults
"After bad things happen, your body may	"Intense emotions may come and go in

have strong feelings that come and go like waves in the ocean. When you feel really bad, that's a good time to talk to your mom and dad to help you calm down."	waves."
"Even adults need help at times like this."	"Shocking experiences may trigger strong, often upsetting, 'alarm' reactions in the body, such as startle reactions."
"Many adults are working together to help with what happened, and to help people recover."	"Sometimes the best way to recover is to take a few moments for calming routines (for example, go for a walk, breathe deeply, practice muscle relaxation techniques)."
"Staying busy can help you deal with your feelings and start to make things better."	"Friends and family are very important sources of support to help calm down."

Adapted from Brymer, M., Jacobs, A., Layne, C., Pynoos, R., Ruzek, J., Steinberg, A., Vernberg, E., & Watson, P. (2006)

- If a person appears extremely agitated, has rushed speech, seems to be losing touch with the surroundings, or is experiencing ongoing intense crying, it may help to:
    - Ask the individual to listen and look at you
    - Find out if s/he knows who s/he is, where s/he is, and what is happening
    - Ask him/her to describe the surroundings and say where the both of you are
- If these actions don't work to stabilize the agitated individual, use "grounding:"
    - Sit in a comfortable position with your legs and arms uncrossed
    - Breathe in and out slowly and deeply
    - Look around you and name five non-distressing objects that you can see. For example you could say, "I see the floor, I see a shoe, I see a table, I see a chair, I see a person"
    - Breathe in and out slowly and deeply
    - Next, name five non-distressing sounds you can hear. For example: "I hear a woman talking, I hear myself breathing, I hear a door close, I hear someone typing, I hear a cell phone ringing"
    - Breathe in and out slowly and deeply
    - Next, name five non-distressing things you can feel. For example: "I can feel this wooden armrest with my hands, I can feel my toes inside my shoes, I can feel my back pressing against my chair, I can feel the blanket in my hands, I can feel my lips pressed together"
    - Breathe in and out slowly and deeply
- If none of these help in emotion stabilization, consult with medical professionals as medication may be needed
    - Medication for acute traumatic stress reactions should not be a routine solution and should only be considered after other ways of helping

    - Medication use should have a specific target (e.g., sleep) and should be time-limited
    - Be mindful that:
        - Exposure to disaster may worsen pre-existing conditions
        - Some may be without their medications or are faced with uncertainty about continued access
        - Communication with their psychiatrists, physicians, or pharmacies may be disrupted
        - Monitoring of medication blood levels may be interrupted
    - Gather information helpful to a referring physician:
        - Current medications
        - Current medications that need ongoing monitoring
        - Access to currently prescribed medications, physicians, and pharmacy
        - Survivor's compliance with medication
        - Substance abuse/recovery issues
        - Ongoing medical and mental health conditions
        - You may need to talk with family and/or friends to get an accurate report if the survivor is too distressed or confused

Information Gathering: Current Needs and Concerns

The goal is to identify and gather information regarding the immediate needs and concerns of survivors, and then tailor Psychological First Aid interventions accordingly. Key points for this include:

- A formal assessment is not appropriate, but you can ask about:
    - Need for immediate referral
    - Need for additional services
    - A follow-up meeting
- You may need to ask questions to clarify the following:
    - Nature and severity of experiences during the disaster
    - Death of a loved one
    - Concerns about immediate post-disaster circumstances and ongoing threat
    - Separation from or concern about the safety of loved ones
    - Physical illness, mental health conditions, and need for medications
    - Losses (home, school, neighborhood, business, property, and pets)
    - Extreme feelings of guilt or shame
    - Thoughts about causing harm to self or others
    - Availability of social support
    - Prior alcohol or drug use
    - Prior exposure to trauma and death of loved ones
    - Specific youth, adult, and family concerns over developmental impact

Practical Assistance

The goal for this core action is to follow-up on the immediate needs and concerns of survivors and offer practical help. Key points for this include:

- Discussing immediate needs and concerns and developing plans to follow through can increase a sense of empowerment and hope for adults, adolescents, and children
- Steps in offering practical assistance:
    - Identify the most immediate needs
    - Clarify the need
    - Discuss an action plan
    - Act to address the need

Connection with Social Supports

The goal is to connect survivors with sources of support, which includes family, friends, and community helping resources. Key points for this include:

- Social support is a very important aspect of the recovery process for survivors
- Enhance access to primary support persons (family and significant others)
- Encourage use of immediately available support persons
- Discuss support-seeking and giving
    - If survivors are reluctant to seek support, it may be because:
        - They don't know what they need
        - They feel embarrassed or weak for needing help
        - They feel guilty about receiving help when others are in greater need
        - They don't know where to turn for help
        - They worry that they will be a burden or depress others
        - They fear that they will get so upset that they lose control
        - They aren't sure if support will be available or helpful
        - They think that no one understands what they're going through
        - They tried to get help and didn't find it (feeling let down or betrayed)
        - They feel that people will get angry or make them feel guilty for needing help
- Special considerations for children and adolescents
- Modeling support with supportive responses (Brymer, M., Jacobs, A., Layne, C., Pynoos, R., Ruzek, J., Steinberg, A., Vernberg, E., & Watson, P., 2006):

- Reflective comments:
  - "From what you're saying, I can see how you would be…"
  - "It sounds like you're saying…"
  - "It seems that you are…"
- Clarifying comments:
  - "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 situations. Maybe 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 difficult, for me, it has helped me to…Do you think something like that would work for you?"

Information on Coping

The goal is to provide information about stress reactions and coping in order to reduce distress. Key points for this include:

- Provide basic information about stress reactions
- Review common psychological reactions to traumatic experiences and losses
- Talking with children about body and emotional reactions
  - Rather than asking children directly to describe their emotions (e.g., sad, scared, confused, etc.), ask them to describe their physical sensations (e.g., "How do you feel inside?")
  - If they are able to talk about emotions, it can be helpful to suggest different feelings for them to choose from (e.g., "Do you feel sad, angry, or okay today?")
  - You can draw, or have the child draw, an outline of a person to help the child talk about his/her physical sensations
- Provide basic information on ways of coping (Table 6)

- Adaptive coping actions: helps to reduce anxiety, lesson distressing reactions, and help people get through difficult times
- Maladaptive coping actions: is ineffective in addressing problems

Table 6
Adaptive and Maladaptive Coping Actions

Adaptive Actions	Maladaptive Actions
Talking to another person for support	Using alcohol or drugs to cope
Getting needed information	Withdrawing from activities
Getting adequate rest, nutrition, exercise	Withdrawing from family or friends
Engaging in positive distracting activities (sports, hobbies, reading)	Working too many hours
	Getting violently angry
Trying to maintain a normal schedule to the extent possible	Excessive blaming of self or others
	Overeating or undereating
Telling yourself that it is natural to be upset for some period of time	Watching too much TV or playing too many computer games
Scheduling pleasant activities	Doing risky or dangerous things
Eating healthful meals	Not taking care of yourself (sleep, diet, exercise, etc.)
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	
Focusing on something practical that you can do right now to manage the situation better	
Using coping methods that have been successful for you in the past	

Adapted from Brymer, M., Jacobs, A., Layne, C., Pynoos, R., Ruzek, J., Steinberg, A., Vernberg, E., & Watson, P. (2006)

- Teach simple relaxation techniques
- Coping for families
  - Encourage families to try and maintain family routines
  - Encourage family members to be understanding, patient, and tolerant of differences in reactions
- Assist with developmental issues
  - Be mindful of developmental milestones (Table 7), as the aftermath of disasters may cause delays or reversals in development

Table 7
Examples of Developmental Milestones

Age	Milestones
Toddlers and preschool-age children	Becoming toilet trained Entering daycare or preschool Learning to ride a tricycle Sleeping through the night Learning or using language
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	Having a new home or moving Having a child leave home Going through a separation or divorce Experiencing the death of a grandparent
All ages	Graduations Birthdays Special events

Adapted from Brymer, M., Jacobs, A., Layne, C., Pynoos, R., Ruzek, J., Steinberg, A., Vernberg, E., & Watson, P. (2006)

- Assist with anger management
    - Explain that anger and frustration are common in disaster survivors
    - Discuss how anger is affecting their life
    - Normalize the experience of anger and discuss how anger can increase interpersonal conflict or potentially lead to violence
    - Ask survivors to identify changes that they would like to make to address their anger
    - Compare how holding to anger can hurt them, while letting go of their anger or directing it toward positive activities can help
    - Anger management skills to suggest:
        - Take a "time out" or "cool down"
        - Talk to a friend about why you're angry
        - Blow off steam by exercising

        - Keep a journal to describe your feelings and what you can do to change the situation
        - Remind yourself that that being angry will not help you achieve what you want and that it may harm relationships
        - Distract yourself with positive activities, like reading a book, praying, listening to music, etc.
        - Look at your situation from a different perspective
        - Children and adolescents like activities that help them express their feelings, like drawing, writing in a journal, playing with situations, composing a song, etc.
        - Help children and adolescents to problem-solve a situation that is angering them
- Address highly negative emotions (guilt and shame)
- Help with sleep problems
- Address alcohol and substance use

Linkage with Collaborative Services

The goal of this core action is to link survivors with available services. Key points for this include:

- Examples of situations that require a referral:
    - Acute medical or mental health problem that needs immediate attention
    - Worsening of a pre-existing medical, emotional, or behavioral problem
    - Threat of harm to self or others
    - Concerns related to alcohol and drug use
    - Cases involving domestic, child, or elder abuse (be aware of reporting laws)
    - When medication is needed for stabilization
    - When spiritual counseling is desired
    - Ongoing difficulties with coping
    - Significant developmental concerns about children or adolescents
    - When the survivor asks for a referral
- Referrals for children and adolescents:
    - Recommend that follow-up services for the family include a brief evaluation of child and adolescent adjustment
    - Make your interactions with children and adolescents positive and supportive
    - Remember that children and adolescents have difficulty telling information about the traumatic event – thus, it is useful to summarize in writing the information so that it can be communicated to the receiving professional
- Referrals for older adults:
    - Make sure that elders have referral sources for the following:

- Primary care physician
- Local senior center
- Council on Aging programs
- Social support services
- Meals on Wheels
- Senior housing or assisted living
- Transportation service

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