Psychological First Aid

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Medical Reserve Corps Field Operations Guide

National Child Traumatic Stress Network

National Center for PTSD

NCTSN The National Child Traumatic Stress Network

National Center for PTSD Post-Traumatic Stress Disorder

medical reserve corps

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National Child Traumatic Stress Network

Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention to cultural perspectives, the NCTSN serves as a national resource for developing and disseminating evidence-based interventions, trauma-informed services, and public and professional education.

National Center for PTSD

VA's National Center for PTSD is a world leader in research and education programs focusing on PTSD and other psychological and medical consequences of traumatic stress. Mandated by Congress in 1989, the Center is a consortium of seven academic centers of excellence providing research, education and consultation in the field of traumatic stress.

The views, opinions, and content are those of the authors, and do not necessarily reflect those of SAMHSA or HHS.

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Psychological First Aid

Field Operations Guide
2nd Edition

Introduction and Overview:

- What is Psychological First Aid?
- Who is Psychological First Aid for?
- Who Delivers Psychological First Aid?
- When Should Psychological First Aid Be Used?
- Where Should Psychological First Aid Be Used?
- Strengths of Psychological First Aid
- Basic Objectives of Psychological First Aid
- Delivering Psychological First Aid

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Introduction and Overview

Psychological First Aid for Medical Reserve Corps

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

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

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

What is Psychological First Aid?

Psychological First Aid is an evidence-informed[1] modular approach to help children, adolescents, adults, and families in the immediate aftermath of disaster and terrorism. Psychological First Aid is designed to reduce the initial distress caused by traumatic events and to foster short- and long-term adaptive functioning and coping. Principles and techniques of Psychological First Aid meet four basic standards. They are:

1. Consistent with research evidence on risk and resilience following trauma
2. Applicable and practical in field settings
3. Appropriate for developmental levels across the lifespan
4. Culturally informed and delivered in a flexible manner

[1]Psychological First Aid is supported by disaster mental health experts as the "acute intervention of choice" when responding to the psychosocial needs of children, adults and families affected by disaster and terrorism. At the time of this writing, this model requires systematic empirical support; however, because many of the components have been guided by research, there is consensus among experts that these components provide effective ways to help survivors manage post-disaster distress and adversities, and to identify those who may require additional services.

What is Psychological First Aid? *- continued*

Psychological First Aid does not assume that all survivors will develop severe mental health problems or long-term difficulties in recovery. Instead, it is based on an understanding that disaster survivors and others affected by such events will experience a broad range of early reactions (for example, physical, psychological, behavioral, spiritual). Some of these reactions will cause enough distress to interfere with adaptive coping, and recovery may be helped by support from compassionate and caring disaster responders.

Who is Psychological First Aid For?

Psychological First Aid intervention strategies are intended for use with children, adolescents, parents/caretakers, families, and adults exposed to disaster or terrorism. Psychological First Aid can also be provided to first responders and other disaster relief workers.

Who Delivers Psychological First Aid?

Psychological First Aid is designed for delivery by mental health and other disaster response workers who provide early assistance to affected children, families, and adults as part of an organized disaster response effort. These providers may be imbedded in a variety of response units, including first responder teams, incident command systems, primary and emergency health care, school crisis response teams, faith-based organizations, Community Emergency Response Teams (CERT), Medical Reserve Corps, the Citizens Corps, and other disaster relief organizations.

When Should Psychological First Aid Be Used?

Psychological First Aid is a supportive intervention for use in the immediate aftermath of disasters and terrorism.

Where Should Psychological First Aid Be Used?

Psychological First Aid is designed for delivery in diverse settings. Mental health and other disaster response workers may be called upon to provide Psychological First Aid in general population shelters, special needs shelters, field hospitals and medical triage areas, acute care facilities (for example, Emergency Departments), staging areas or respite centers for first responders or other relief workers, emergency operations centers, crisis hotlines or phone banks, feeding locations, disaster assistance service centers, family reception and assistance centers, homes, businesses, and other community settings. For more information on the challenges of providing Psychological First Aid in various service settings, see Appendix B.

Strengths of Psychological First Aid

- Psychological First Aid includes basic information-gathering techniques to help providers make rapid assessments of survivors' immediate concerns and needs, and to implement supportive activities in a flexible manner.
- Psychological First Aid relies on field-tested, evidence-informed strategies that can be provided in a variety of disaster settings.
- Psychological First Aid emphasizes developmentally and culturally appropriate interventions for survivors of various ages and backgrounds.
- Psychological First Aid includes handouts that provide important information for youth, adults, and families for their use over the course of recovery.

Basic Objectives of Psychological First Aid

- Establish a human connection in a non-intrusive, compassionate manner.
- Enhance immediate and ongoing safety, and provide physical and emotional comfort.
- Calm and orient emotionally overwhelmed or distraught survivors.
- Help survivors to tell you specifically what their immediate needs and concerns are, and gather additional information as appropriate.
- Offer practical assistance and information to help survivors address their immediate needs and concerns.
- Connect survivors as soon as possible to social support networks, including family members, friends, neighbors, and community helping resources.
- Support adaptive coping, acknowledge coping efforts and strengths, and empower survivors; encourage adults, children, and families to take an active role in their recovery.
- Provide information that may help survivors cope effectively with the psychological impact of disasters.
- Be clear about your availability, and (when appropriate) link the survivor to another member of a disaster response team or to local recovery systems, mental health services, public-sector services, and organizations.

Delivering Psychological First Aid

Professional Behavior

- Operate only within the framework of an authorized disaster response system.
- Model healthy responses; be calm, courteous, organized, and helpful.

Professional Behavior - *continued*

- Be visible and available.
- Maintain confidentiality as appropriate.
- Remain within the scope of your expertise and your designated role.
- Make appropriate referrals when additional expertise is needed or requested by the survivor.
- Be knowledgeable and sensitive to issues of culture and diversity.
- Pay attention to your own emotional and physical reactions, and practice self-care.

Guidelines for Delivering Psychological First Aid

- Politely observe first; don't intrude. Then ask simple respectful questions to determine how you may help.
- Often, the best way to make contact is to provide practical assistance (food, water, blankets).
- Initiate contact only after you have observed the situation and the person or family, and have determined that contact is not likely to be intrusive or disruptive.
- Be prepared that survivors will either avoid you or flood you with contact.
- Speak calmly. Be patient, responsive, and sensitive.
- Speak slowly, in simple concrete terms; don't use acronyms or jargon.
- If survivors want to talk, be prepared to listen. When you listen, focus on hearing what they want to tell you, and how you can be of help.
- Acknowledge the positive features of what the survivor has done to keep safe.
- Give information that directly addresses the survivor's immediate goals and clarify answers repeatedly as needed.
- Give information that is accurate and age-appropriate for your audience.
- When communicating through a translator or interpreter, look at and talk to the person you are addressing, not at the translator or interpreter.
- Remember that the goal of Psychological First Aid is to reduce distress, assist with current needs, and promote adaptive functioning, not to elicit details of traumatic experiences and losses.

Some Behaviors to Avoid

- Do not make assumptions about what survivors are experiencing or what they have been through.
- Do not assume that everyone exposed to a disaster will be traumatized.
- Do not pathologize. Most acute reactions are understandable and expectable given what people exposed to the disaster have experienced. Do not label reactions as "symptoms," or speak in terms of "diagnoses," "conditions," "pathologies," or "disorders."
- Do not talk down to or patronize the survivor, or focus on his/her helplessness, weaknesses, mistakes, or disability. Focus instead on what the person has done that is effective or may have contributed to helping others in need, both during the disaster and in the present setting.
- Do not assume that all survivors want to talk or need to talk to you. Often, being physically present in a supportive and calm way helps affected people feel safer and more able to cope.
- Do not "debrief" by asking for details of what happened.
- Do not speculate or offer possibly inaccurate information. If you cannot answer a survivor's question, do your best to learn the facts.

Working With Children and Adolescents

- For young children, sit or crouch at the child's eye level.
- Help school-age children verbalize their feelings, concerns and questions; provide simple labels for common emotional reactions (for example, mad, sad, scared, worried). Do not use extreme words like "terrified" or "horrified" because this may increase their distress.
- Listen carefully and check in with the child to make sure you understand him/her.
- Be aware that children may show developmental regression in their behavior and use of language.
- Match your language to the child's developmental level. Younger children typically have less understanding of abstract concepts like "death." Use direct and simple language as much as possible.
- Talk to adolescents "adult-to-adult," so you give the message that you respect their feelings, concerns, and questions.
- Reinforce these techniques with the child's parents/caregivers to help them provide appropriate emotional support to their child.

Working with Older Adults

- Older adults have strengths as well as vulnerabilities. Many older adults have acquired effective coping skills over a lifetime of dealing with adversities.
- For those who may have a hearing difficulty, speak clearly and in a low pitch.
- Don't make assumptions based only on physical appearance or age, for example, that a confused elder has irreversible problems with memory, reasoning, or judgment. Reasons for apparent confusion may include: disaster-related disorientation due to change in surroundings; poor vision or hearing; poor nutrition or dehydration; sleep deprivation; a medical condition or problems with medications; social isolation; and feeling helpless or vulnerable.
- An older adult with a mental health disability may be more upset or confused in unfamiliar surroundings. If you identify such an individual, help to make arrangements for a mental health consultation or referral.

Working With Survivors with Disabilities

- When needed, try to provide assistance in an area with little noise or other stimulation.
- Address the person directly, rather than the caretaker, unless direct communication is difficult.
- If communication (hearing, memory, speech) seems impaired, speak simply and slowly.
- Take the word of a person who claims to have a disability–even if the disability is not obvious or familiar to you.
- When you are unsure of how to help, ask, "What can I do to help?" and trust what the person tells you.
- When possible, enable the person to be self-sufficient.
- Offer a blind or visually impaired person your arm to help him/her move about in unfamiliar surroundings.
- If needed, offer to write down information and make arrangements for the person to receive written announcements.
- Keep essential aids (such as medications, oxygen tank, respiratory equipment, and wheelchair) with the person.

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Preparing to Deliver Psychological First Aid:

- Entering the Setting
- Providing Services
- Group Settings
- Maintain a Calm Presence
- Be Sensitive to Culture and Diversity
- Be Aware of At-Risk Populations

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Preparing to Deliver Psychological First Aid

In order to be of assistance to disaster-affected communities, the Psychological First Aid provider must be knowledgeable about the nature of the event, current circumstances, and the type and availability of relief and support services.

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

Entering the Setting

Psychological First Aid begins when a disaster response worker enters an emergency management setting in the aftermath of a disaster (See Appendix B for descriptions of various service delivery sites). Successful entry involves working within the framework of an authorized Incident Command System (ICS) in which roles and decision-making are clearly defined. It is essential to establish communication and coordinate all activities with authorized personnel or organizations that are managing the setting. Effective entry also includes learning as much as you can about the setting, for example, leadership, organization, policies and procedures, security, and available support services. You need to have accurate information about what is going to happen, what services are available, and where they can be found. This information needs to be gathered as soon as possible, given that providing such information is often critical to reducing distress and promoting adaptive coping.

Providing Services

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

- Disoriented
- Confused
- Frantic or agitated

Providing Services - *continued*

- Panicky
- Extremely withdrawn, apathetic, or "shut down"
- Extremely irritable or angry
- Exceedingly worried

Group Settings

While Psychological First Aid is primarily designed for working with individuals and families, many components can be used in group settings, such as when families gather together for information about loved ones and for security briefings. The components of providing information, support, comfort, and safety can be applied to these spontaneous group situations. For groups of children and adolescents, offering games for distraction can reduce anxiety and concern after hours and days in a shelter setting.

When meeting with groups, keep the following in mind:

- Tailor the discussion to the group's shared needs and concerns.
- Focus the discussion on problem-solving and applying coping strategies to immediate issues.
- Do not let discussion about concerns lapse into complaints.
- If an individual needs further support, offer to meet with him/her after the group discussion.

Maintain a Calm Presence

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

Be Sensitive to Culture and Diversity

Providers of Psychological First Aid must be sensitive to culture, ethnic, religious, racial, and language diversity. Whether providing outreach or services, you should be aware of your own values and prejudices, and how these may agree with or differ from those of the community being served. Training in cultural competence can facilitate this awareness. Helping to maintain or reestablish customs, traditions, rituals, family structure, gender roles, and social bonds is important in helping survivors cope with the impact of a disaster. Information about the community being served, including how emotions and other psychological reactions are

expressed, attitudes toward government agencies, and receptivity to counseling, should be gathered with the assistance of community cultural leaders who represent and best understand local cultural groups.

Be Aware of At-Risk Populations

Individuals that are at special risk after a disaster include:

- 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 (for example, home, pets, family memorabilia)
- Those exposed first hand to grotesque scenes or extreme life threat

Especially in economically disadvantaged groups, a high percentage of survivors may have experienced prior traumatic events (for example, death of a loved one, assault, disaster). As a consequence, minority and marginalized communities may have higher rates of pre-existing trauma-related mental health problems, and are at greater risk for developing problems following disaster. Mistrust, stigma, fear (for example, of deportation), and lack of knowledge about disaster relief services are important barriers to seeking, providing, and receiving services for these populations. Those living in disaster-prone regions are more likely to have had prior disaster experiences.

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Core Actions:

- Contact and Engagement
- Safety and Comfort
- Stabilization
- Information Gathering: Current Needs and Concerns
- Practical Assistance
- Connection with Social Supports
- Information on Coping
- Linkage with Collaborative Services

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Core Actions

Psychological First Aid Core Actions

1. **Contact and Engagement**

   Goal: To respond to contacts initiated by survivors, or to initiate contacts in a non-intrusive, compassionate, and helpful manner.

2. **Safety and Comfort**

   Goal: To enhance immediate and ongoing safety, and provide physical and emotional comfort.

3. **Stabilization** (if needed)

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

4. **Information Gathering: Current Needs and Concerns**

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

5. **Practical Assistance**

   Goal: To offer practical help to survivors in addressing immediate needs and concerns.

6. **Connection with Social Supports**

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

7. **Information on Coping**

   Goal: To provide information about stress reactions and coping to reduce distress and promote adaptive functioning.

8. **Linkage with Collaborative Services**

   Goal: To link survivors with available services needed at the time or in the future.

These core actions of Psychological First Aid constitute the basic objectives of providing early assistance within days or weeks following an event. Providers should be flexible, and base the amount of time they spend on each core action on the survivors' specific needs and concerns.

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Contact and Engagement:

- Introduce Yourself/Ask about Immediate Needs
- Confidentiality

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1. Contact and Engagement

Goal: To respond to contacts initiated by survivors, or to initiate contacts in a non-intrusive, compassionate, and helpful manner.

Your first contact with a survivor is important. If managed in a respectful and compassionate way, you can establish an effective helping relationship and increase the person's receptiveness to further help. Your first priority should be to respond to survivors who seek you out. If a number of people approach you simultaneously, make contact with as many individuals as you can. Even a brief look of interest and calm concern can be grounding and helpful to people who are feeling overwhelmed or confused.

Culture Alert: The type of physical or personal contact considered appropriate may vary from person to person and across cultures and social groups, for example, how close to stand to someone, how much eye contact to make or whether or not to touch someone, especially someone of the opposite sex. Unless you are familiar with the culture of the survivor, you should not approach too closely, make prolonged eye contact, or touch. You should look for clues to a survivor's need for "personal space," and seek guidance about cultural norms from community cultural leaders who best understand local customs. In working with family members, find out who is the spokesperson for the family and initially address this person.

Some survivors may not seek your help, but may benefit from assistance. When you identify such persons, timing is important. Do not interrupt conversations. Do not assume that people will respond to your outreach with immediate positive reactions. It may take time for some survivors or bereaved persons to feel some degree of safety, confidence, and trust. If an individual declines your offer of help, respect his/her decision and indicate when and where to locate a Psychological First Aid provider later on.

Introduce Yourself/Ask about Immediate Needs

Introduce yourself with your name, title, and describe your role. Ask for permission to talk to him/her, and explain that you are there to see if you can be of help. Unless given permission to do otherwise, address adult survivors using last names. Invite the person to sit, try to ensure some level of privacy for the conversation, and give the person your full attention. Speak softly and calmly. Refrain from looking around or being distracted. Find out whether there is any pressing problem that needs immediate attention. Immediate medical concerns have the utmost priority.

When making contact with children or adolescents, it is good practice to first make a connection with a parent or accompanying adult to explain your role and seek permission. If you speak with a child in distress when no adult is present, find a parent or caregiver as soon as possible to let him/her know about your conversation.

Introduce Yourself/Ask about Immediate Needs - *continued*

For example, in making initial contact, you might say:

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

Confidentiality

Protecting the confidentiality of your interactions with children, adults, and families after a disaster can be challenging, especially given the lack of privacy in some post-disaster settings. However, maintaining the highest level of confidentiality possible in any conversation you have with survivors or disaster responders is extremely important. If you are a professional who belongs to a category of mandated reporters, you should abide by state abuse and neglect reporting laws. You should also be aware of the ***Health Insurance Portability and Accountability Act*** (HIPAA) and the provisions related to disaster and terrorism. If you have questions about releasing information, discuss this with a supervisor or an official in charge. Talking to co-workers about the challenges of working in the post-disaster environment can be helpful, but any discussions organized for this purpose also need to preserve strict confidentiality.

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Safety and Comfort:

- Ensure Immediate Physical Safety
- Provide Information about Disaster Response Activities and Services
- Attend to Physical Comfort
- Promote Social Engagement
- Attend to Children Who Are Separated from their Parents/ Caregivers
- Protect from Additional Traumatic Experiences and Trauma Reminders
- Help Survivors Who Have a Missing Family Member
- Help Survivors When a Family Member or Close Friend has Died
- Attend to Grief and Spiritual Issues
- Provide Information about Casket and Funeral Issues
- Attend to Issues Related to Traumatic Grief
- Support Survivors Who Receive Death Notification
- Support Survivors Involved in Body Identification
- Help Caregivers Confirm Body Identification to a Child or Adolescent

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2. Safety and Comfort

Goal: To enhance immediate and ongoing safety, and provide physical and emotional comfort.

Restoration of a sense of safety is an important goal in the immediate aftermath of disaster and terrorism. Promoting safety and comfort can reduce distress and worry. Assisting survivors in circumstances of missing loved ones, death of loved ones, death notification and body identification is a critical component of providing emotional comfort and support.

Comfort and safety can be supported in a number of ways, including helping survivors:

- Do things that are active (rather than passive waiting), practical (using available resources), and familiar (drawing on past experience).
- Get current, accurate and up-to-date information, while avoiding survivors' exposure to information that is inaccurate or excessively upsetting.
- Get connected with available practical resources.
- Get information about how responders are making the situation safer.
- Get connected with others who have shared similar experiences.

Ensure Immediate Physical Safety

Make sure that individuals and families are physically safe to the extent possible. If necessary, reorganize the immediate environment to increase physical and emotional safety. For example:

- Find the appropriate officials who can resolve safety concerns that are beyond your control, such as threats, weapons, etc.
- Remove broken glass, sharp objects, furniture, spilled liquids, and other objects that could cause people to trip and fall.
- Make sure that children have a safe area in which to play and that they are adequately supervised.
- Be aware and ensure the safety of survivors in a particular subgroup that may be targeted for persecution based on their ethnicity, religion, or other affiliations.

To promote safety and comfort for survivors who are elderly or disabled, you can:

- Help make the physical environment safer (for example, try to ensure adequate lighting, and protect against slipping, tripping, and falling).
- Ask specifically about his/her needs for eyeglasses, hearing aids, wheelchairs, walkers, canes, or other devices. Try to ensure that all essential aids are kept with the person.

Ensure Immediate Physical Safety - *continued*

- Ask whether the survivor needs help with health-related issues or daily activities (for example, assistance with dressing, use of bathroom, daily grooming, and meals).
- Inquire about current need for medication. Ask if he/she has a list of current medications or where this information can be obtained, and make sure he/she has a readable copy of this information to keep during the post-disaster period.
- Consider keeping a list of survivors with special needs so that they can be checked on more frequently.
- Contact relatives, if they are available, to further ensure safety, nutrition, medication, and rest. Make sure that the authorities are aware of any daily needs that are not being met.

If there are medical concerns requiring urgent attention or immediate need for medication, contact the appropriate unit leader or medical professional immediately. Remain with the affected person or find someone to stay with him/her until you can obtain help. Other safety concerns involve:

- Threat of harm to self or others–Look for signs that persons may hurt themselves or others (for example, the person expresses intense anger towards self or others, exhibits extreme agitation). If so, seek immediate support for containment and management by medical, EMT assistance, or a security team.
- Shock–If an individual is showing signs of shock (pale, clammy skin; weak or rapid pulse; dizzy; irregular breathing; dull or glassy eyes; unresponsive to communication; lack of bladder or bowel control; restless, agitated, or confused), seek immediate medical support.

Providing Information about Disaster Response Activities and Services

To help reorient and comfort survivors, provide information about:

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

In providing information:

- Use your judgment as to *whether* and *when* to present information. Does the individual appear able to comprehend what is being said, and is he/she ready to hear the content of the messages?

- Address immediate needs and concerns to reduce fears, answer pressing questions, and support adaptive coping.
- Use clear and concise language, while avoiding technical jargon.

Ask survivors if they have any questions about what is going to happen, and give simple accurate information about what they can expect. Also, ask whether he/she has any special needs that the authorities should know about in order to decide on the best placement. Be sure to ask about concerns regarding current danger and safety in their new situation. Try to connect survivors with information that addresses these concerns. If you do not have specific information, do not guess or invent information in order to provide reassurance. Instead, develop a plan with the person for ways you and he/she can gather the needed information. Examples of what you might say include:

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

Do not reassure people that they are safe unless you have definite factual information that this is the case. Also do not reassure people of the availability of goods or services (for example, toys, food, medicines) unless you have definite information that such goods and services will be available. However, do address safety concerns based on your understanding of the current situation. For example, you may say:

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

Look for simple ways to make the physical environment more comfortable. If possible, consider things like temperature, lighting, air quality, access to furniture, and how the furniture is arranged. In order to reduce feelings of helplessness or dependency, encourage survivors to participate in getting things needed for comfort (for example, offer to walk over to the supply area with the person rather than retrieving supplies for him/her). Help survivors to soothe and comfort themselves and others around them. For children, toys like soft teddy bears that they can hold and take care of can help them to soothe themselves. However, avoid offering such toys if there are not enough to go around to all children who may request them. You can help children learn how to take care of themselves by explaining how they can "care" for their toy (for example, "Remember that she needs to drink lots of water and eat three meals a day–and you can do that, too").

When working with the elderly or people with disabilities, pay attention to factors that may increase their vulnerability to stress or worsen medical conditions. When attending to the physical needs of these survivors, be mindful of:

- Health problems, such as physical illness, problems with blood pressure, fluid and electrolyte balance, respiratory issues (supplemental oxygen dependency), frailty (increased susceptibility to falls, minor injuries, bruising, and temperature extremes)
- Age-related sensory loss:
  - Visual loss, which can limit awareness of surroundings and add to confusion
  - Hearing loss, resulting in gaps in understanding of what others are saying
- Cognitive problems, such as difficulty with attention, concentration, and memory
- Lack of mobility
- Unfamiliar or over-stimulating surroundings
- Noise that can limit hearing and interfere with hearing devices
- Limited access to bathroom facilities or mass eating areas, or having to wait in long lines (A person who has not needed a wheelchair before the event may need one now.)
- Concern for the safety of a service animal

Promote Social Engagement

Facilitate group and social interactions as appropriate. It is generally soothing and reassuring to be near people who are coping adequately with the situation. On the other hand, it is upsetting to be near others who appear very agitated and emotionally

overwhelmed. If survivors have heard upsetting information or been exposed to rumors, help to clarify and correct misinformation.

Children, and to some extent adolescents, are particularly likely to look to adults for cues about safety and appropriate behavior. When possible, place children near adults or peers who appear relatively calm, and when possible, avoid putting them too close to individuals who are extremely upset. Offer brief explanations to children and adolescents who have observed extreme reactions in other survivors.

Child/Adolescent	That man is so upset that he can't calm down yet. Some people take longer to calm down than others. Someone from our team is coming over to help him calm down. If you feel upset, it is important for you to talk to your mom or dad, or someone else who can help you feel better.

As appropriate, encourage people who are coping adequately to talk with others who are distressed or not coping as well. Reassure them that talking to people, especially about things they have in common (for example, coming from nearby neighborhoods or having children about the same age), can help them support one another. This often reduces a sense of isolation and helplessness in both parties. For children, encourage social activities like reading out loud, doing a joint art activity, and playing cards, board games, or sports.

Attend to Children Who Are Separated from their Parents/Caregivers

Parents and caregivers play a crucial role in children's sense of safety and security. If children are separated from their caregivers, helping them reconnect quickly is a high priority. If you encounter an unaccompanied child, ask for information (such as their name, parent/caregiver and sibling names, address, and school), and notify the appropriate authorities. Provide children accurate information in easy-to-understand terms about who will be supervising them and what to expect next. Do not make any promises that you may not be able to keep, such as promising that they will see their caregiver soon. You may also need to support children while their caregivers are being located or during periods when caregivers may be overwhelmed and not emotionally accessible to their children. This support can include setting up a child-friendly space.

Set Up a Child-Friendly Space

- Help to create a designated child-friendly space, such as a corner or a room that is safe, out of high traffic areas, and away from rescue activities.
- Arrange for this space to be staffed by caregivers with experience and skill in working with children of different ages.
- Monitor who comes in and out of the child area to ensure that children do not leave with an unauthorized person.

Set Up a Child-Friendly Space - *continued*

- Stock the child-friendly space with materials for all age ranges. This can include kits with toys, playing cards, board games, balls, paper, crayons, markers, books, safety scissors, tape, and glue.
- Activities that are calming include playing with Legos, wooden building blocks, or play dough, doing cut-outs, working on coloring books (containing neutral scenes of flowers, rainbows, trees, or cute animals) and playing team games.
- Invite older children or adolescents to serve as mentors/role models for younger children, as appropriate. They can do this by helping you conduct group play activities with younger children, or by reading a book to them or playing with them.
- Set aside a special time for adolescents to get together to talk about their concerns, and to engage in age-appropriate activities like listening to music, playing games, making up and telling stories, or making a scrapbook.

Protect from Additional Traumatic Experiences and Trauma Reminders

In addition to securing physical safety, it is also important to protect survivors from unnecessary exposure to additional traumatic events and trauma reminders, including sights, sounds, or smells that may be frightening. To help protect their privacy, shield survivors from reporters, other media personnel, onlookers, or attorneys. Advise adolescents that they can decline to be interviewed by the media, and that if they wish to be interviewed, they may want to have a trusted adult with them.

If survivors have access to media coverage (for example, television or radio broadcasts), point out that excessive viewing of such coverage can be highly upsetting, especially for children and adolescents. Encourage parents to monitor and limit their children's exposure to the media, and to discuss any concerns after such viewing. Parents can let their children know that they are keeping track of information, and to come to them for updates instead of watching television. Remind parents to be careful about what they say in front of their children, and to clarify things that might be upsetting to them. For example, you might say:

Adult/Caregiver	You've been through a lot, and it's a good idea to shield yourself and your children from further frightening or disturbing sights and sounds as much as possible. Even televised scenes of the disaster can be very disturbing to children. You may find that your children feel better if you limit their television viewing of the disaster. It doesn't hurt for adults to take a break from all the media coverage, too.

Adolescent/Child	You've been through a lot already. People often want to watch TV or go to the internet after something like this, but doing this can be pretty scary. It's best to stay away from TV or radio programs that show this stuff. You can also tell your mom or dad if you see something that bothers you.

Help Survivors Who Have a Missing Family Member

Coping while a loved one is missing is extremely difficult. Family members may experience a number of different feelings: denial, worry, hope, anger, shock, or guilt. They may alternate between certainty that the person is alive—even in the face of contradictory evidence—and hopelessness and despair. They may blame authorities for not having answers, for not trying hard enough, or for delays. They may also feel vengeful against those that they consider responsible for locating their missing relative or friend. It is extremely important to reassure children that the family, police, and other first responders are doing everything possible to find the missing loved one.

Assist family members who have a missing loved one by helping them obtain updated information about missing persons, direct them to locations for updated briefings, and tell them the plan in place for connecting/reuniting survivors. The American Red Cross has established a "Disaster Welfare Information System" to support family communication and reunification, and a "Safe and Well" website located at www.redcross.org. It provides a variety of tools and services needed to communicate with loved ones during times of emergency. Try to identify other official sources of updated information (police, official radio and television channels, etc.) and share these with survivors.

You may want to take extra time with survivors worried over a missing family member. Just being there to listen to survivors' hopes and fears, and being honest in giving information and answering questions is often deeply appreciated. To help locate a missing family member, you can make an initial review with the family of any pre-disaster plans for post-disaster contact, including school or workplace evacuation plans; plans for tracking transport of students or co-workers for medical care; out-of-state telephone numbers to be used by schools, workplaces, or families in case of emergency; and any pre-arranged or likely meeting places (including homes of relatives), both within and outside the disaster perimeter.

Some family members may want to leave a safe area to attempt to find or rescue a missing loved one. In this case, inform the survivor about the current circumstances in the search area, specific dangers, needed precautions, the efforts of first responders, and when updated information may be available. Discuss specific concerns they may have (for example, an elderly parent who recently had hip surgery, or a child who needs special medications), and offer to inform the appropriate authorities.

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

Help Survivors Who Have a Missing Family Member - *continued*

It can be disturbing and confusing for a child to be present at a caregiver's interview with authorities or to hear adult speculations about what might have happened to the missing person. Authorities may ask a family member to collect DNA from a loved one's personal effects, for example, hair from a hairbrush. In rare cases, a child may need to be interviewed because he/she was the last one to see the missing person. A mental health or forensic professional trained to interview children should conduct the interview or be present. A supportive family member or you should accompany the child. Talk to the child simply and honestly. For example, you might say:

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

Sometimes in the case of missing persons, the evidence will strongly suggest that the person is dead. There may be disagreement among family members about the status of their loved one. You should let family members know that these differences (some giving up hope, some remaining hopeful) are common in a family when a loved one is missing, and not a measure of how much they love the person or each other. You can encourage family members to be patient, understanding, and respectful of each other's feelings until there is more definite news. Parents/caregivers should not assume that it is better for a child to keep hoping that the person is alive, but instead honestly share the concern that the loved one may be dead. Parents/caregivers should check with children to make sure that they have understood, and ask what questions they have.

Help Survivors When a Family Member or Close Friend has Died

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

Acute Grief Reactions are likely to be intense and prevalent among those who have suffered the death of a loved one or close friend. They may feel sadness and anger over the death, guilt over not having been able to prevent the death, regret about not providing comfort, or having a proper leave-taking, missing the deceased, and wishing for reunion (including dreams of seeing the person again). Although painful to experience at first, grief reactions are healthy responses that reflect the significance of the death. Over time, grief reactions tend to include more pleasant thoughts and activities, such as telling positive stories about a loved one, and comforting ways of remembering him/her. You should remember:

- Treat acutely bereaved children and adults with dignity, respect, and compassion.
- Grief reactions vary from person to person.
- There is no single "correct" course of grieving.
- Grief puts people at risk for abuse of over-the-counter medications, increased smoking, and consumption of alcohol. Make survivors aware of these risks, the importance of self-care, and the availability of professional help.

In working with survivors who have experienced the death of a family member or close friend, you can:

- Discuss how family members and friends will each have their own special set of reactions; no particular way of grieving is right or wrong, and there is not a "normal" period of time for grieving. What is most important for family members and friends is to respect and understand how each may be experiencing their own course of grief.
- Discuss with family members and friends how culture or religious beliefs influence how people grieve and especially how rituals may or may not satisfy current feelings of each family member.
- Keep in mind that children may only show their grief for short periods of time each day, and even though they may play or engage in other positive activities, their grief can be just as strong as that of any other family member.

To emphasize how important is it for family members to understand and respect each other's course of grief, you may say:

Adult/Adolescent/ Child	It is important to know that each family member may express their grief differently. Some may not cry, while others might cry a lot. Family members should not feel badly about this or think there is something wrong with them. What is most important is to respect the different ways each feels, and help each other in the days and weeks ahead.

Help Survivors When a Family Member or Close Friend has Died - *continued*

Some children and adolescents will not have words to describe their feelings of grief and may resist talking with others about how they feel. Sometimes, distracting activities will be more calming than conversation, for example, drawing, listening to music, reading, etc. Some may wish to be alone. If safe, provide them with some privacy. When a survivor does want to talk with you about the loved one, you should listen quietly, and not feel compelled to talk a lot. Do not probe.

Do:

- Reassure grieving individuals that what they are experiencing is understandable and expectable.
- Use the deceased person's name, rather than referring to him/her as "the deceased."
- Let them know that they will most likely continue to experience periods of sadness, loneliness, or anger.
- Tell them that if they continue to experience grief or depression that affects daily functioning, talking to a member of the clergy or a counselor who specializes in grief is advisable.
- Tell them that their doctor, their city or county department of mental health, or their local hospital can refer them to appropriate services.

Don't say:

- I know how you feel.
- It was probably for the best.
- He is better off now.
- It was her time to go.
- At least he went quickly.
- Let's talk about something else.
- You should work towards getting over this.
- You are strong enough to deal with this.
- You should be glad he passed quickly.
- That which doesn't kill us makes us stronger.
- You'll feel better soon.
- You did everything you could.
- You need to grieve.
- You need to relax.

- It's good that you are alive.
- It's good that no one else died.
- It could be worse; you still have a brother/sister/mother/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.

If the grieving person says any of the above things, you can respectfully acknowledge the feeling or thought, but don't initiate a statement like these yourself.

Child and adolescent understanding of death varies depending on age and prior experience with death, and is strongly influenced by family, religious, and cultural values.

- Pre-school children may not understand that death is permanent, and may believe that if they wish it, the person can return. They need help to confirm the physical reality of a person's death–that he/she is no longer breathing, moving or having feelings–and has no discomfort or pain. They may be concerned about something bad happening to another family member.
- School-age children may understand the physical reality of death, but may personify death as a monster or skeleton. In longing for his/her return, they may experience upsetting feelings of the "ghostlike" presence of the lost person, but not tell anyone.
- Adolescents generally understand that death is irreversible. Losing a family member or friend can trigger rage and impulsive decisions, such as quitting school, running away, or abusing substances. These issues need prompt attention by the family or school.

The death of a parent/caregiver affects children differently depending on their age.

- Pre-school children need consistent care and a predictable daily routine as soon as possible. They can be easily upset by change: food prepared differently, their special blanket missing, or being put into bed at night without the usual person or in a different way. Caregivers (including the surviving parent) should ask the child if they are doing something differently or something "wrong" (for example, "Am I not doing this the way Mommy did?").
- A school-age child loses not only his/her primary caregiver, but also the person who would normally be there to comfort him/her and help with daily activities. Other caregivers should try, as best they can, to assume these roles. Children may be angry at a substitute caregiver, especially when disciplined. Caregivers should acknowledge that the child is missing his/her parent/caregiver, and then provide extra comfort.
- Adolescents may experience an intense sense of unfairness, and protest over the death. They may have to take on greater responsibilities within their family and resent not being

Help Survivors When a Family Member or Close Friend has Died - *continued*

able to have more independence or do the things that adolescents normally do. Over time, caregivers should discuss how to balance these different needs.

You may give parents/caregivers some **suggestions for talking with children and adolescents about death.** These include:

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

You should give information to parents/caregivers and children about reactions to the death that they might experience. The handout, ***When Terrible Things Happen*** (Appendix E), describes common reactions to the death of a loved one and ways of coping. When speaking to parents/caregivers, you can say:

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

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

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

Attend to Grief and Spiritual Issues

In order to assist survivors with spiritual needs after a death, you should become familiar with clergy who may be part of the disaster response team on-site, and with ways to obtain contact information for clergy of local religious groups to whom you can refer survivors. It is common for people to rely on religious and spiritual beliefs/practices as a way to cope with the death of a loved one. Survivors may use religious language to talk about what is happening or want to engage in prayer or other religious practices. It is not necessary for you to share these beliefs in order to be supportive. You are not required to do or say anything that violates your own beliefs. Often, simply listening and attending is all that is required. Things to keep in mind include:

- A good way to introduce this topic is to ask, "Do you have any religious or spiritual needs at this time?" This question is not meant to lead to a theological discussion or to your engaging in spiritual counseling. If requested, you can refer them to a clergy member of their choice.
- Do not contradict or try to "correct" what a person says about his/her religious beliefs, even if you disagree and think that it may be causing them distress.
- Do not try to answer religious questions like, "Why was this allowed to happen?" These questions generally represent expressions of emotion rather than real requests for an answer.
- If a person is clearly religious, ask if he/she wants to see a clergy member of his/her faith.
- Many people rely on religious objects such as prayer beads, statues, or sacred texts that they may have lost or left behind. Locating an object like this can help to increase their level of security and sense of control. A local clergy member can often be of help in providing these items.

Attend to Grief and Spiritual Issues - *continued*

- Survivors may want to pray alone or in a group. You may help by finding a suitable place for them to do so. For some people, facing in the proper direction while praying is important. You can help to orient them.
- You may also provide information to officials in charge regarding space and religious items needed for religious observances.
- If you are asked to join in prayer, you may decline if you feel uncomfortable. Keep in mind that joining may only involve standing in silence while they pray. If you are comfortable joining in at the end with an "Amen," this can help your relationship with the person and the family.
- Many people routinely light candles or incense when they pray. If not allowed in the setting, explain this to survivors, and assist them in finding a nearby place where an open flame would be allowed.
- A survivor may voice hope for a miracle, even in the face of virtual certainty that their loved one has died. Do not take this as evidence that he/she has lost touch with reality or has not heard what has been said, but as the survivor's way of continuing to function in devastating circumstances. It is important to neither encourage or discourage such hope.
- Every religion has specific practices around death, particularly in regard to the care of dead bodies. These issues may be especially complicated when the body is not recovered. Ask survivors about their religious needs in this area. They may want a clergy member to advise them.
- In some cultures, expressions of grief can be very loud and may seem out of control. It may be helpful to move families to a more private space to prevent them from upsetting others. If the behavior is upsetting to you, you should find someone else to assist the family.
- If a survivor expresses anger associated with his/her religious beliefs (a sign of spiritual distress), do not judge or argue with him/her. Most people are not looking for an "answer," but a willing, non-judgmental listener. If spiritual concerns are contributing to significant distress, guilt, or functional impairment, you can ask if he/she would like a referral to a clergy member.

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

Provide Information about Casket and Funeral Issues

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

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

You can assist family members with their **questions about children's attendance at a funeral, memorial service, or gravesite**. In responding to questions, keep the following in mind:

- It can be helpful for a child to attend a funeral. Although emotionally challenging, funerals help children accept the physical reality of the death which is part of grieving. If not included, children can feel left out of something important to the family.
- Parents/caregivers should give children a choice whether or not to attend a funeral or other ritual. They may be encouraged, but should not be pressured.
    - Before asking children to choose, tell them what to expect if they attend, including letting them know that adults may be upset and crying. Explain that there will be a special area for the family to sit together (if that is to be arranged). Let them know what will happen during the service.
    - Give them an opportunity to choose the person that they will sit next to at the service. Make sure that this person can pay appropriate attention to them.
    - Always provide a way for children to leave the service with that person, even temporarily, if they become overwhelmed.
    - Tell children about alternative arrangements if they do not wish to attend, such as staying with a neighbor or friend of the family.
    - If they choose not to attend, offer to say something or read something on their behalf, and explain how they can participate in memorial activities at a later time, including memorials of their own making.
- If possible, bring younger children to the location early so that they can explore the space. Describe the casket and, if they wish, join them in approaching it. Caution should be exercised in regard to allowing young children to view or touch the body. A young child can use a photograph of the person to help say goodbye.
- For younger children, reinforce that the deceased family member is not in distress.

Provide Information about Casket and Funeral Issues - *continued*

You may be asked to attend funerals or other events. You may feel that this will help a family member or child. Attend funerals only with the permission and knowledge of the family.

Attend to Issues Related to Traumatic Grief

After traumatic death, some survivors may stay focused on the circumstances of the death, including being preoccupied with how the death could have been prevented, what the last moments were like, and who was at fault. These reactions may interfere with grieving, making it more difficult for survivors to adjust to the death. These reactions include:

- Intrusive, disturbing images of the death that interfere with positive remembering and reminiscing
- Retreat from close relationships with family and friends
- Avoidance of usual activities because they are reminders of the traumatic death
- For children, repetitive play that includes themes involving the traumatic circumstances of the death

These reactions can change mourning, often putting individuals on a different time course than may be experienced by other family members. You may want to speak privately to a family member who was present at the time of the death in order to advise him/her about the extra burden of witnessing the death. Let him/her know that talking to a mental health professional or clergy member may be very helpful. For example, you might say:

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

Support Survivors Who Receive Death Notification

Although it is unlikely that you will be asked to notify a family member of a death, you may assist family members who have been informed of a death. You may be asked by police, FBI, hospital personnel or Disaster Mortuary Operational Response Team (DMORT) members to be present at the time of death notification. In some catastrophic situations, such as airline crashes, the news media may report that there were no survivors of the accident before family members have been officially notified. As incorrect information is sometimes circulated by the media or other survivors–caution family members to wait for official confirmation from the authorities.

After learning of the death of a family member or close friend, people may have psychological and physiological reactions that vary from agitation to numbness. At the same time, they must cope with the continuing stress of still being in the disaster environment. In providing support, keep the following in mind:

- Don't rush. Family members need time to process the news and ask questions.
- Allow for initial strong reactions: these will likely improve over time.
- When talking about a person who is a confirmed fatality, use the word "died," not "lost" or "passed away."
- Remember that family members do not want to know how YOU feel (sympathy); they want to know you are trying to understand how THEY feel (empathy).

Active steps to help support survivors in dealing with death notification include:

- Seek assistance from medical support personnel if a medical need arises.
- Get help from the authorities if family members are at risk for hurting themselves or others.
- Make sure that social supports are available, such as family, friends, neighbors, or clergy.
- Try to work with individuals or family units. Even when officials are addressing large crowds, it is better to have family members assembled at their own tables with you present. Potentially traumatic activities–such as reviewing passenger manifests, ticket lists, or morgue photos–should be done in family groups, in a private location, with the appropriate authorities. Be careful that children and adolescents do not see morgue photos.
- If an unaccompanied child is told that his/her caregiver has died, stay with the child or ensure that another worker stays with the child until he/she is reunited with other family members or is attended to by an appropriate child protective service worker.

Children may have a range of responses to being told of the death of a loved one. They may act as if they did not hear, they may cry or protest the news, or they may not speak for an extended period. They may be angry with the person who told them. You may suggest that the parent/caretaker say something like:

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

Support Survivors Who Receive Death Notification - *continued*

For adolescents, you can advise parents to caution teens about doing something risky, like storming off, driving while overwhelmed with such news, staying out late, engaging in high-risk sexual behavior, using alcohol or other drugs, or acting in some other reckless way. Parents/caretakers should also understand that an adolescent's anger can turn to rage over the loss, and they should be prepared to tolerate some expressions of rage. However, they should also be firm in addressing any behavioral risks. Expression of any suicidal thought should be taken seriously, and appropriate additional assistance should be immediately sought. Expressions of revenge should also be taken seriously. Adolescents should be cautioned to think about the consequences of revenge, and be encouraged to consider constructive ways to respond to their feelings.

Family members should address immediate questions from children and adolescents about their living circumstances and who will take care of them. You may suggest that separation of siblings be avoided, if at all possible.

Support Survivors Involved in Body Identification

Where identifiable bodies have been recovered and family members have been asked to assist in the identification process, authorities may take family members to the morgue or an alternative location to view and identify the body. The Psychological First Aid provider will typically not participate in these activities, but may be of assistance prior to and after body identification. Some individuals may feel that they must see the body before they can accept that the person is dead. Adolescents and older children might ask to be present when the body is identified; however, in most cases, children should be discouraged from participating in the process. Children may not understand the extent to which the body has deteriorated or changed, and may find seeing the body extremely disturbing. Parents can say to the child:

Parent/Caregivers	You know, Uncle Bobby wouldn't want you to see him that way. I'm going to go and make sure that it's him, but I don't feel that you should go and see the body.

When the body is found, it is natural for families to want to know when and where it was found, and what the person experienced before dying. Family members may be more disturbed by unanswered questions, than by having those questions answered. You should expect a wide range of reactions after viewing the body, including shock, numbness, fainting, vomiting, trembling, screaming, or hitting something or someone.

Help Caregivers Confirm Body Identification to a Child or Adolescent

After a family member has identified the body of a loved one, a caregiver should convey this to children. You may sit in to provide support and assistance. Since young children do not understand that death is final, a family member should make it very clear that the lost loved one's body has been found, and that he/she is dead. If the identification was made through forensic methods, it is important to explain the certainty of the identification in simple direct language. Parents should reassure children that the loved one is not suffering, that they were very loved by him/her, and that they will be taken care of. Allow children to ask questions, and–if an answer is not readily available–let them know that the parent or you will try to get additional information. You should caution parents/caretakers about giving disturbing details of the physical appearance of the body. If the child asks about the appearance, a parent can say:

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

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Stabilization:

- Stabilize Emotionally Overwhelmed Survivors
- Orient Emotionally Overwhelmed Survivors
- The Role of Medications in Stabilization

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3. Stabilization (if needed)

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

Most individuals affected by disasters will not require stabilization. Expressions of strong emotions, even muted emotions (for example, numb, indifferent, spaced-out, or confused) are expectable reactions, and do not of themselves signal the need for additional intervention beyond ordinary supportive contact. While expression of strong emotions, numbing, and anxiety are normal and healthy responses to traumatic stress, extremely high arousal, numbing, or extreme anxiety can interfere with sleep, eating, decision-making, parenting, and other life tasks. You should be concerned about those individuals whose reactions are so intense and persistent that they significantly interfere with a survivor's ability to function.

Stabilize Emotionally Overwhelmed Survivors

Observe individuals for these signs of being disoriented or overwhelmed:

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

If the **person is too upset, agitated, withdrawn, or disoriented to talk, or shows extreme anxiety, fear, or panic,** consider:

- Is the person with family and friends? If so, enlist them in comforting the distressed person. You may want to take a distressed individual to a quiet place, or speak quietly with that person while family/friends are nearby.
- What is the person experiencing? Is he/she crying, panicking, experiencing a "flashback," or imagining that the event is taking place again? When intervening, address the person's primary immediate concern or difficulty, rather than simply trying to convince the person to "calm down" or to "feel safe" (neither of which tends to be effective).

Stabilize Emotionally Overwhelmed Survivors - *continued*

For children or adolescents, consider:

- Is the child or adolescent with his/her parents? If so, briefly make sure that the adult is stable. Focus on empowering the parents in their role of calming their children. Do not take over for the parents, and avoid making any comments that may undermine their authority or ability to handle the situation. Let them know that you are available to assist in any way that they find helpful.
- If emotionally overwhelmed children or adolescents are separated from their parents, or if their parents are not coping well, refer below to the options for stabilizing distressed persons.

In general, the following steps will help **to stabilize the majority of distressed individuals:**

- Respect the person's privacy, and give him/her a few minutes before you intervene. Say you will be available if they need you or that you will check back with them in a few minutes to see how they are doing and if there is anything you can do to help at that time.
- Remain calm, quiet, and present, rather than trying to talk directly to the person, as this may contribute to cognitive/emotional overload. Just remain available, while giving him/her a few minutes to calm down.
- Stand close by as you talk to other survivors, do some paperwork, or other tasks while being available should the person need or wish to receive further help.
- Offer support and help him/her focus on specific manageable feelings, thoughts, and goals.
- Give information that orients him/her to the surroundings, such as how the setting is organized, what will be happening, and what steps he/she may consider.

Orient Emotionally Overwhelmed Survivors

Use these points to help survivors understand their reactions:

Adults

- Intense emotions may come and go in waves.
- Shocking experiences may trigger strong, often upsetting, "alarm" reactions in the body, such as startle reactions.
- 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).
- Friends and family are very important sources of support to help calm down.

Children and Adolescents

- After bad things happen, your body may 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.
- Even adults need help at times like this.
- Many adults are working together to help with what happened, and to help people recover.
- Staying busy can help you deal with your feelings and start to make things better.

Caution adolescents about doing something risky or impulsive, without discussing it with a parent or trusted adult. For example, you might say:

Adolescent/Child	When something bad like this happens, it is really important to get support from adults that you trust. Is there anyone who helps you feel better when you talk to them? Maybe I can help you get in touch with them.

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

- Ask the individual to listen to you and look at you.
- Find out if he/she knows who he/she is, where he/she is, and what is happening.
- Ask him/her to describe the surroundings, and say where both of you are.

If none of these actions seems to help **to stabilize an agitated individual, a technique called "grounding" may be helpful.** You can introduce grounding by saying:

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

- 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.

Orient Emotionally Overwhelmed Survivors - *continued*

- 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.

You might have children name colors that they see around them. For example, say to the child, "Can you name five colors that you can see from where you are sitting. Can you see something blue? Something yellow? Something green?"

If none of these interventions aids in emotional stabilization, consult with medical or mental health professionals, as medication may be needed. Modify these interventions for a person who has difficulty with vision, hearing, or expressive language.

The Role of Medications in Stabilization

In most cases, the above-described ways of stabilizing survivors will be adequate. Medication for acute traumatic stress reactions is not recommended as a routine way of meeting the goals of Psychological First Aid, and medication should be considered only if an individual has not responded to other ways of helping. Any use of medication in survivors should have a specific target (for example, sleep and control of panic attacks), and should be time-limited. Medications may be necessary when the survivor is experiencing extreme agitation, extreme anxiety and panic, psychosis, or is dangerous to self or others.

You should be mindful of the following:

- Exposure to disaster may worsen pre-existing conditions (for example, schizophrenia, depression, anxiety, pre-existing PTSD).
- Some survivors may be without their medications, or face uncertainty about continued access to medications.
- Communication with their psychiatrists, physicians, or pharmacies may be disrupted.
- Monitoring of medication blood levels may be interrupted.

Gather information that will be helpful when referring to a physician, including:

- List of current medications
- Current medications that require ongoing monitoring by a physician
- Access to currently prescribed medications, doctors, and dispensing pharmacy
- The survivor's compliance with medication
- Substance abuse/recovery issues
- Ongoing medical and mental health conditions

You may obtain more information about current medications from family and friends if the survivor is too distressed or confused to give an accurate report.

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Information Gathering: Needs and Current Concerns

- 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, Personal 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

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4. Information Gathering: Needs and Current Concerns

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

You should be flexible in providing Psychological First Aid, and should adapt interventions for specific individuals, and their identified needs and concerns. Gather enough information so that you can tailor and prioritize your interventions to meet these needs. Gathering and clarifying information begins immediately after contact and continues throughout Psychological First Aid.

Remember that in most Psychological First Aid settings, your ability to gather information will be limited by time, survivors' needs and priorities, and other factors. Although a formal assessment is not appropriate, you may ask about:

- Need for immediate referral
- Need for additional services
- Offering a follow-up meeting
- Using components of Psychological First Aid that may be helpful

The form, ***Survivor Current Needs*** (Appendix D), may be helpful in documenting the basic information gathered from survivors. Likewise, the ***Psychological First Aid Provider Worksheet*** (Appendix D) may be useful in documenting services provided. These forms are designed for use within an incident command system for evaluation purposes, and where there are proper safeguards for confidentiality.

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

Nature and Severity of Experiences during the Disaster

Survivors who experienced direct life-threat to self or loved ones, injury to self, or those who witnessed injury or death are at increased risk for more severe and prolonged distress. Those who felt extremely terrified and helpless may also have more difficulty in recovering. For information about the survivor's experiences, you may ask:

	You've been through a lot of difficult things. May I ask you some questions about what you have been through? Where were you during the disaster? Did you get hurt? Did you see anyone get hurt? How afraid were you?

Nature and Severity of Experiences during the Disaster - *continued*

Provider Alert: In clarifying disaster-related traumatic experiences, avoid asking for in-depth descriptions that may provoke additional distress. Follow the survivor's lead in discussing what happened. Don't press survivors to disclose details of any trauma or loss. On the other hand, if they are anxious to talk about their experiences, politely and respectfully tell them that what would be most helpful now is to get some *basic* information so that you can help with their current needs, and plan for future care. Let them know that the opportunity to discuss their experiences in a proper setting can be arranged for the future.

For survivors with these kind of experiences, provide information about post-disaster reactions and coping (see Information on Coping), and offer a follow-up meeting. For those who were injured, arrange medical consultation as appropriate.

Death of a Loved One

The death of loved ones under traumatic circumstances is devastating, and over time can greatly complicate the grieving process. Ask about the death of loved ones with a question like:

	Did someone close to you get hurt or die as a result of the disaster? Who got hurt or died?

For those who experienced the death of a loved one, provide emotional comfort, information about coping, social support, and acute grief, and offer a follow-up meeting.

Concerns about Immediate Post-Disaster Circumstances and Ongoing Threat

Survivors may be highly concerned about immediate and ongoing danger. You may ask questions like:

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

For those with these concerns, help them obtain information about safety and protection.

Separation from or Concern about the Safety of Loved Ones

Separation from loved ones and concern about their safety is an additional source of distress. If not addressed earlier, get information with questions like these:

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

For survivors with these concerns, provide practical assistance in connecting them with available information sources and registries that can help locate and reunite family members. See Safety and Comfort and Connection with Social Supports.

Physical Illness, Mental Health Conditions, and Need for Medications

Pre-existing medical or mental heath conditions and need for medications are additional sources of post-disaster distress. Those with a history of psychological problems may experience a worsening of these problems, as well as more severe and prolonged post-disaster reactions. Give a high priority to immediate medical and mental health concerns. Ask questions like:

	Do you have any medical or mental health condition that needs attention? Do you need any medications that you don't have? Do you need to have a prescription filled? Can you get in touch with your doctor?

For those with medical or mental health conditions, provide practical assistance in obtaining medical or psychological care and medication.

Losses (Home, School, Neighborhood, Business, Personal Property, and Pets)

If survivors have extensive material losses and post-disaster adversities, their recovery may be complicated with feelings of depression, demoralization, and hopelessness. For information about such loss, ask questions like:

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

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

Extreme Feelings of Guilt or Shame

Extreme negative emotions can be very painful, difficult, and challenging, especially for children and adolescents. Children and adults may be ashamed to discuss these feelings. Listen carefully for signs of guilt or shame in their comments. To further clarify, you may say:

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

For those experiencing guilt or shame, provide emotional comfort and information about coping with these emotions. This can be found in the section, Information on Coping.

Thoughts about Causing Harm to Self or Others

It is a priority to get a sense of whether an individual is having thoughts about causing harm to self or others. To explore these thoughts and feelings, ask questions like:

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

For those with these thoughts, get medical or mental health assistance immediately. If the survivor is at immediate risk of hurting themselves or others, stay with him/her until appropriate personnel arrive on the scene and assume management of the survivor.

Availability of Social Support

Family, friends, and community support can greatly enhance the ability to cope with distress and post-disaster adversity. Ask about social support as follows:

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

For those lacking adequate social support, help them connect with available resources and services, provide information about coping and social support, and offer a follow-up meeting.

Provider Alert: In clarifying prior history of substance use, prior trauma and loss, and prior mental health problems, you should be sensitive to the immediate needs of the survivor, avoid asking for a history if not appropriate, and avoid asking for in-depth description. Give clear reasons for asking (for example, "Sometimes events like this can remind individuals of previous bad times . . ." "Sometimes individuals who use alcohol to cope with stress will notice an increase in drinking following an event such as this . . .")

Prior Alcohol or Drug Use

Exposure to trauma and post-disaster adversities can increase substance use, cause relapse of past substance abuse, or lead to new abuse. Get information about this by asking:

Adult/Caregiver/ Adolescent	Has your use of alcohol, prescription medications, or drugs increased since the disaster? Have you had any problems in the past with alcohol or drug use? Are you currently experiencing withdrawal symptoms from drug use?

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

Prior Exposure to Trauma and Death of Loved Ones

Those with a history of exposure to trauma or death of loved ones may experience more severe and prolonged post-disaster reactions and a renewal of prior trauma and grief reactions. For information about prior trauma, ask:

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

For those with prior exposure and/or loss, provide information about post-disaster and grief reactions, information about coping and social support, and offer a follow-up meeting.

Specific Youth, Adult, and Family Concerns over Developmental Impact

Survivors can be very upset when the disaster or its aftermath interferes with upcoming special events, including important developmental activities (for example, birthdays, graduation, start of school or college, marriage, vacation). For information about this, ask:

	Were there any special events coming up that were disrupted by the disaster?

For those with developmental concerns, provide information about coping and assist with strategies for practical help.

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

	Is there anything else we have not covered that you are concerned about or want to share with me?

If the survivor identifies multiple concerns, summarize these and help to identify which issues are most pressing. Work with the survivor to prioritize the order in which concerns should be addressed.

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Practical Assistance:

- Offering Practical Assistance to Children and Adolescents
- Identify the Most Immediate Needs
- Clarify the Need
- Discuss an Action Plan
- Act to Address the Need

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5. Practical Assistance

Goal: To offer practical help to survivors in addressing immediate needs and concerns.

Exposure to disaster, terrorism and post-event adversities is often accompanied by a loss of hope. Those who are likely to have more favorable outcomes are those who maintain one or more of the following characteristics:

- Optimism (because they can have hope for their future)
- Confidence that life is predictable
- Belief that things will work out as well as can reasonably be expected
- Belief that outside sources act benevolently on one's behalf (responsive government)
- Strong faith-based beliefs
- Positive belief (for example, "I'm lucky, things usually work out for me")
- Resources, including housing, employment, financial

Providing people with needed resources can increase a sense of empowerment, hope, and restored dignity. Therefore, assisting the survivor with current or anticipated problems is a central component of Psychological First Aid. Survivors may welcome a pragmatic focus and assistance with problem-solving.

Discussion of immediate needs occurs throughout a Psychological First Aid contact. As much as possible, help the survivor address the identified needs, as problem-solving may be more difficult under conditions of stress and adversity. Teaching individuals to set achievable goals may reverse feelings of failure and inability to cope, help individuals to have repeated success experiences, and help to reestablish a sense of environmental control necessary for successful disaster recovery.

Offering Practical Assistance to Children and Adolescents

Like adults, children and adolescents benefit from clarifying their needs and concerns, developing a plan to address them, and acting on the plan. Their ability to clarify what they want, think through alternatives, select the best option, and follow through develops gradually. For example, many children can participate in problem-solving, but require the assistance of adolescents or adults to follow through with their plans. When appropriate, share the plans you have developed with parents/caregivers, or involve parents/caregivers in making the plans, so that they can help the child or adolescent to carry them through. Offering practical assistance is composed of four steps:

Step 1: Identify the Most Immediate Needs

If the survivor has identified several needs or current concerns, it will be necessary to focus on them one at a time. For some needs, there will be immediate solutions (for example, getting something to eat, phoning a family member to reassure them that the survivor is okay). Other problems (for example, locating a lost loved one, returning to previous routines, securing insurance for lost property, acquiring caregiving services for family members) will not be solved quickly, but the survivor may be able to take concrete steps to address the problem (for example, completing a missing persons report or insurance form, applying for caregiving services).

As you collaborate with the survivor, help him/her select issues requiring immediate help. For example, you might say:

Adult/Caregiver	I understand from what you're telling me, Mrs. Williams that your main goal right now is to find your husband and make sure he's okay. We need to focus on helping you get in contact with him. Let's make a plan on how to go about getting this information.
Adolescent/Child	It sounds like you are really worried about several different things, like what happened to your house, when your dad is coming, and what will happen next. Those are all important things, but let's think about what is most important right now, and then make a plan.

Step 2: Clarify the Need

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

Step 3: Discuss an Action Plan

Discuss what can be done to address the survivor's need or concern. The survivor may say what he/she would like to be done, or you can offer a suggestion. If you know what services are available ahead of time, you can help obtain food, clothing, shelter, or medical care; mental health or spiritual care services; financial assistance; help in locating missing family members or friends; and volunteer opportunities for those who want to contribute to relief efforts. Tell survivors what they can realistically expect in terms of potential resources and support, qualification criteria, and application procedures.

Step 4: Act to Address the Need

Help the survivor to take action. For example, help him/her set an appointment with a needed service or assist him/her in completing paperwork.

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Connection with Social Supports:

- Enhance Access to Primary Support Persons (Family and Significant Others)
- Encourage Use of Immediately Available Support Persons
- Discuss Support-Seeking and Giving
- Special Considerations for Children and Adolescents
- Modeling Support

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6. Connection with Social Supports

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

Social support is related to emotional well-being and recovery following disaster and terrorism. People who are well connected to others are more likely to engage in supportive activities (both receiving and giving support) that assist with disaster recovery. Social support can come in many forms. These include:

- ***Emotional Support:*** hugs, a listening ear, understanding, love, acceptance
- ***Social Connection:*** feeling like you fit in and have things in common with other people, having people to share activities
- ***Feeling Needed:*** feeling that you are important to others, that you are valued, useful and productive, and that people appreciate you
- ***Reassurance of Self-Worth:*** having people help you have confidence in yourself and your abilities, that you can handle the challenges you face
- ***Reliable Support:*** having people reassure you that they will be there for you in case you need them, that you have people you can rely on to help you
- ***Advice and Information:*** having people show you how to do something or give you information or good advice, having people help you understand that your way of reacting to what has happened is common, having good examples to learn from about how to cope in positive ways with what is happening
- ***Physical Assistance:*** having people help you perform tasks, like carrying things, fixing up your house or room, and helping you do paperwork
- ***Material Assistance:*** having people give you things, like food, clothing, shelter, medicine, building materials, or money

Fostering connections as soon as possible and assisting survivors in developing and maintaining social connections is critical to recovery. Benefits of social connectedness include:

- Increased opportunities for knowledge essential to disaster recovery
- Opportunities for a range of social support activities, including:
    - Practical problem-solving
    - Emotional understanding and acceptance
    - Sharing of experiences and concerns
    - Clarifying reactions
    - Sharing information about coping

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

An immediate concern for most survivors is to contact those with whom they have a primary relationship (for example, spouse/partner, children, parents, other family members, close friends, neighbors, and clergy). Take practical steps to assist survivors to reach these individuals (in person, by phone, by e-mail, through web-based databases). Other sources of social support may include co-workers and hobby or club members (such as an afterschool club, bridge club, book club, Rotary, or VFW). Survivors who belong to religious organizations may have access to a valuable supportive network that can help facilitate recovery.

Encourage Use of Immediately Available Support Persons

If individuals are disconnected from their social support network, encourage them to make use of immediately available sources of social support (for example, yourself, other relief workers, other survivors), while being respectful of individual preferences. It can help to offer reading materials (for example, magazines, newspapers, fact sheets), and discuss the material with them. When people are in a group, ask if they have questions. When members of the group are from different neighborhoods or communities, facilitate introductions among members. Small group discussions can provide a starting point for further conversations and social connectedness. When working with the frail elderly, you may try to connect them with a younger adult or adolescent volunteer, if available, who can provide social contact and assistance with daily activities. If appropriate, you may offer them the opportunity to assist families by spending time with younger children (reading to them, sitting with them while they play, or playing games with them).

When working with youth, bring similar-age children together in a shared activity–as long as they know where their adult caregivers are. Provide art materials, coloring books, or building materials to help younger children engage in soothing, familiar activities. Older children and adolescents can lead younger children in activities. Children may have suggestions of songs to sing or classroom games that they have played at school. Several activities that can be done only with paper and pencil include:

- Tic-tac-toe
- Folding “fortune tellers”
- Making paper balls and tossing them into an empty wastebasket
- Air hockey: wad up a piece of paper and have children try to blow it across the table into the other team’s goal (Bonus: can be used to practice deep breathing exercises).
- Group drawing: have children sit in a circle, the first child begins a drawing. After 10 seconds, that child passes the drawing to the child on their right. Continue until everyone has added to the drawing. Then show the group the final picture. Suggest

that the children draw something positive (not pictures of the disaster), something that promotes a sense of protection and safety.

- Scribble game: pair up youth, one person makes a scribble on the paper, and their partner has to add to the scribble to turn it into something.
- Making a paper doll chain or circle chain in which the child writes the name of each person in their support system on a link. For adolescents, you can also ask them to identify the type of support (for example, emotional support, advice and information, material assistance, etc.) that they receive from each person.

Discuss Support-Seeking and Giving

If individuals are reluctant to seek support, there may be many reasons, including:

- Not knowing what they need (and perhaps feeling that they should know).
- Feeling embarrassed or weak because of needing help.
- Feeling guilty about receiving help when others are in greater need.
- Not knowing where to turn for help.
- Worrying that they will be a burden or depress others.
- Fearing that they will get so upset that they will lose control.
- Doubting that support will be available or helpful.
- Thinking, “No one can understand what I’m going through.”
- Having tried to get help and finding that help wasn’t there (feeling let down or betrayed).
- Fearing that the people they ask will be angry or make them feel guilty for needing help.

In helping survivors to appreciate the value of social support and to engage with others, you may need to address some of the above concerns.

For those who have become withdrawn or socially isolated, you can be of assistance by helping them to:

- Think about the type of support that would be most helpful.
- Think about whom they can approach for that type of support.
- Choose the right time and place to approach the person.
- Talk to the person and explain how he/she can be of help.
- Afterwards, thank the person for his/her time and help.

Discuss Support-Seeking and Giving - *continued*

Let survivors know that, following a disaster, some people choose not to talk about their experiences, and that spending time with people one feels close to without talking can feel good. For example, your message might be:

Adult/Caregiver	When you're able to leave the Assistance Center you may just want to be with the people you feel close to. You may find it helpful to talk about what each of you has been through. You can decide when and what to talk about. You don't have to talk about everything that occurred, only what you choose to share with each person.
Adolescent	When something really upsetting like this happens, even if you don't feel like talking, be sure to ask for what you need.
Child	You are doing a great job letting grown-ups know what you need. It is important to keep letting people know how they can help you. The more help you get, the more you can make things better. Even grown-ups need help at a time like this.

For those who would like to provide support to others, you can help them to:

- Identify ways that they can be helpful to others (volunteer in the shelter or community, help children or older adults).
- Identify a person or persons that they can help.
- Find an uninterrupted time and place to talk or to help them.
- Show interest, attention, and care.
- Offer to talk or spend time together as many times as needed.

The focus should not be on discussing disaster-related experiences or loss, but rather on providing practical assistance and problem-solving current needs and concerns.

Special Considerations for Children and Adolescents

You can help children and adolescents problem-solve ways in which they can ask for, and give support to, others around them. Here are some suggestions:

- Talk with your parents/caregivers or other trusted adults about how you are feeling, so that they better understand how and when to help you.
- Do enjoyable activities with other children, including playing sports, games, board games, watching movies, and so forth.

- Spend time with your younger brothers or sisters. Help them to calm down, play with them, and keep them company.
- Help with cleaning, repairs, or other chores to support your family and community.
- Share things with others, including activities and toys.

In some cases, children and adolescents will not feel comfortable talking with others. Engaging them in social or physical activities or merely being present can be comforting. Parents and you can be supportive by going for a walk, throwing a ball, playing a game, thumbing through magazines together, or simply sitting together.

Modeling Support

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

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."

Modeling Support - *continued*

- "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?"

If appropriate, distribute handouts, ***Connecting with Others: Seeking Social Support and Giving Social Support*** provided in Appendix E. These handouts are intended for adults and older adolescents.

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Information on Coping:

- Provide Basic Information about Stress Reactions
- Review Common Psychological Reactions to Traumatic Experiences and Losses
- Talking with Children about Body and Emotional Reactions
- Provide Basic Information on Ways of Coping
- Teach Simple Relaxation Techniques
- Coping for Families
- Assisting with Developmental Issues
- Assist with Anger Management
- Address Highly Negative Emotions
- Help with Sleep Problems
- Address Alcohol and Substance Abuse

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7. Information on Coping

Goal: To provide information about stress reactions and coping to reduce distress and promote adaptive functioning.

Disasters can be disorienting, confusing, and overwhelming, putting survivors at risk for losing their sense of competence to handle problems that they face. Feeling one can cope with disaster-related stress and adversity is beneficial to recovery.

Various types of information can help survivors manage their stress reactions and deal more effectively with problems. Such information includes:

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

Provide Basic Information about Stress Reactions

If appropriate, briefly discuss common stress reactions experienced by the survivor. Stress reactions may be alarming. Some will be frightened or alarmed by their own responses; some may view their reactions in negative ways (for example, "There's something wrong with me" or "I'm weak"). You should take care to avoid pathologizing survivor responses; do not use terms like "symptoms" or "disorder." You may also see positive reactions, including appreciating life, family, and friends, or strengthening of spiritual beliefs and social connections.

Provider Alert. While it may be helpful to describe common stress reactions and to note that intense reactions are common but often diminish over time, it is also important to avoid providing "blanket" reassurance that stress reactions will disappear. Such reassurances may set up unrealistic expectations about the time it takes to recover.

Review Common Psychological Reactions to Traumatic Experiences and Losses

For survivors who have had significant exposure to trauma and have sustained significant losses, provide basic psychoeducation about common distress reactions. You can review these, emphasizing that such reactions are understandable and expectable. Inform survivors that, if these reactions continue to interfere with their ability to function adequately for over a month, psychological services should be considered. The following basic information is presented as an overview for the Psychological First Aid provider so that you can discuss issues arising from survivors' post-disaster reactions.

Review Common Psychological Reactions to Traumatic Experiences and Losses *- continued*

There are three types of posttraumatic stress reactions:

1. ***Intrusive reactions*** are ways in which the traumatic experience comes back to mind. These reactions include distressing thoughts or mental images of the event (for example, picturing what one saw), or dreams about what happened. Among children, bad dreams may not be specifically about the disaster. Intrusive reactions also include upsetting emotional or physical reactions to reminders of the experience. Some people may feel and act like one of their worst experiences is happening all over again. This is called a "flashback."

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

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

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

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

Loss Reminders can also be sights, sounds, places, smells, specific people, the time of day, situations, or feelings. Examples include seeing a picture of a lost loved one, or seeing their belongings, like their clothes. Loss reminders bring to mind the absence of a loved one. Missing the deceased can bring up strong feelings, like sadness, nervousness, uncertainty about what life will be without them, anger, feeling alone or abandoned, or hopelessness. Loss reminders can also lead to avoiding things that people want to do or need to do.

Change Reminders can be people, places, things, activities, or hardships that remind someone of how life has changed as a result of the disaster. This can be something like waking up in a different bed in the morning, going to a different school, or being in a

different place. Even nice things can remind a survivor of how life has changed, and make the person miss what has been lost.

Hardships often follow in the wake of disasters and can make it more difficult to recover. Hardships place additional strains on survivors and can contribute to feelings of anxiety, depression, irritability, uncertainty, and mental and physical exhaustion. Examples of hardships include: loss of home or possessions, lack of money, shortages of food or water, separations from friends and family, health problems, the process of obtaining compensation for losses, school closures, being moved to a new area, and lack of fun activities.

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

Grief Reactions will be prevalent among those who survived the disaster but have suffered many types of losses, including the death of loved ones, and loss of home, possessions, pets, schools, and community. Loss may lead to feelings of sadness and anger, guilt or regret over the death, missing or longing for the deceased, and dreams of seeing the person again. More information on grief reactions and how to respond to survivors experiencing acute grief reactions can be found in the section on Safety and Comfort.

Traumatic Grief Reactions occur when children and adults have suffered the traumatic death of a loved one. Some survivors may stay focused on the circumstances of the death, including being preoccupied with how the death could have been prevented, what the last moments were like, and who was at fault. These reactions may interfere with grieving, making it more difficult for survivors to adjust to the death over time. More information on traumatic grief reactions and how to respond can be found in the section on Safety and Comfort.

Depression is associated with prolonged grief reactions and strongly related to the accumulation of post-disaster adversities. Reactions include persistent depressed or irritable mood, loss of appetite, sleep disturbance, greatly diminished interest or pleasure in life activities, fatigue or loss of energy, feelings of worthlessness or guilt, feelings of hopelessness, and sometimes thoughts about suicide. Demoralization is a common response to unfulfilled expectations about improvement in post-disaster adversities and resignation to adverse changes in life circumstances.

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

Several handouts found in Appendix E may be useful. ***When Terrible Things Happen*** describes common adult and adolescent reactions, and positive/negative coping. ***Parent Tips for Helping Infants and Toddlers; Parent Tips for Helping Preschool-Age Children; Parent Tips for Helping School-Age Children; Parent Tips for Helping Adolescents; and Tips for Adults*** are for adults to help themselves and their children.

Talking with Children about Body and Emotional Reactions

Children vary in their capacity to make connections between events and emotions. Many children will benefit from a basic explanation of how disaster-related experiences produce upsetting emotions and physical sensations. Suggestions for working with children include:

- Don't ask children directly to describe their emotions (like telling you that they feel sad, scared, confused, or angry), as they often have a hard time finding the words. Instead, ask them to tell you about physical sensations, for example: "How do you feel inside? Do you feel something like butterflies in your stomach or tight all over?"
- If they are able to talk about emotions, it is helpful to suggest different feelings and ask them to pick one ("Do you feel sad right now, or scared, or do you feel okay?") rather than asking open-ended questions ("How are you feeling?").
- You can draw (or ask the child to draw) an outline of a person and use this to help the child talk about his/her physical sensations.

The following gives a basic explanation that helps children to talk about common emotional and physical reactions to disaster.

Adolescent/Child	When something really bad happens, kids often feel funny, strange, or uncomfortable, like their heart is beating really fast, their hands feel sweaty, their stomach hurts, or their legs or arms feel weak or shaky. Other times kids just feel funny inside their heads, almost like they are not really there, like they are watching bad things happening to someone else. Sometimes your body keeps having these feelings for a while even after the bad thing is over and you are safe. These feelings are your body's way of telling you again how bad the disaster was. Do you have any of these feelings, or other ones that I didn't talk about? Can you tell me where you feel them, and what they feel like? Sometimes these strange or uncomfortable feelings come up when kids see, hear, or smell things that remind them of what happened, like strong winds, glass breaking, the smell of smoke, etc. It can be very scary for kids to have these feelings in their bodies, especially if they don't know why they are happening or what to do about them. If you like, I can tell you some ways to help yourself feel better. Does that sound like a good idea?

Provide Basic Information on Ways of Coping

You can discuss a variety of ways to effectively cope with post-disaster reactions and adversity.

Adaptive coping actions are those that help to reduce anxiety, lessen other distressing reactions, improve the situation, or help people get through bad times. In general, coping methods that are likely to be helpful include:

- Talking to another person for support
- Getting needed information
- Getting adequate rest, nutrition, exercise
- Engaging in positive distracting activities (sports, hobbies, reading)
- Trying to maintain a normal schedule to the extent possible
- Telling yourself that it is natural to be upset for some period of time
- Scheduling pleasant activities
- Eating healthful meals
- Taking breaks
- Spending time with others
- Participating in a support group
- Using relaxation methods
- Using calming self talk
- Exercising in moderation
- Seeking counseling
- Keeping a journal
- 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

Maladaptive coping actions tend to be ineffective in addressing problems. Such actions include:

- Using alcohol or drugs to cope
- Withdrawing from activities
- Withdrawing from family or friends

Provide Basic Information on Ways of Coping - *continued*

- Working too many hours
- Getting violently angry
- Excessive blaming of self or others
- Overeating or undereating
- Watching too much TV or playing too many computer games
- Doing risky or dangerous things
- Not taking care of yourself (sleep, diet, exercise, etc.)

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

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

To help children and adolescents identify positive and negative forms of coping, you can write on slips of paper ways that the child is currently using to cope. Then talk with the child about adaptive and maladaptive coping strategies. Have the child sort the pieces of paper into each category and then discuss ways the child can increase their adaptive coping strategies. For younger children, play a memory game in which each coping strategy is written on two pieces of paper. Place the blank sides of each paper face up, and have the child find matching pairs. Once the child gets a pair, discuss with them if this is a good or bad strategy to feel better.

The handout, ***When Terrible Things Happen*** (Appendix E), reviews positive and negative coping for adult and adolescent survivors.

Teach Simple Relaxation Techniques

Breathing exercises help reduce feelings of over-arousal and physical tension which, if practiced regularly, can improve sleep, eating, and functioning. Simple breathing exercises can be taught quickly. It is best to teach these techniques when the survivor is calm and can pay attention. It may also be helpful for family members to prompt each other to use and practice these techniques regularly. The handout, ***Tips for Relaxation*** (Appendix E), can be provided to reinforce the use and practice of relaxation techniques. To teach a breathing exercise, you might say:

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

If you find out that a survivor has previously learned some relaxation technique, try to reinforce what he/she has already learned rather than teaching new skills.

Coping for Families

Reestablishing family routines to the extent possible after a disaster is important for family recovery. Encourage parents and caregivers to try to maintain family routines such as meal times, bedtime, wake time, reading time, and play time, and to set aside time for the family to enjoy activities together.

If a family member has a pre-existing emotional or behavioral problem that has been worsened by the current events, discuss with the family strategies that they may have learned from a therapist to manage these problems. Discuss ways that these strategies may be adapted for the current setting. If the family member continues to have difficulties, consider a mental health consultation.

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

Coping for Families - *continued*

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

You should **encourage family members to be understanding, patient, and tolerant of differences in their reactions**, and to talk about things that are bothering them, so the others will know when and how to support them. Family members can help each other in a number of ways, like listening and trying to understand, comforting with a hug, doing something thoughtful like writing a note, or getting his/her mind off things by playing a game. Parents need to pay special attention to how their children may be troubled by reminders and hardships, because they can strongly affect how their children react and behave. For example, a child may look like he/she is having a temper tantrum, when actually he/she has been reminded of a friend who was hurt or killed.

When disasters confront adults with danger and loss, adolescents may find afterwards that their parents/caretakers have become more anxious about their safety and, consequently, more restrictive in what they allow adolescents to do. You can **help adolescents understand the increase in their caregivers' protective behaviors**–such as earlier curfews, not letting adolescents go off by themselves without adult supervision, insisting that they call in frequently, or not letting adolescents do things that involve some "everyday" risk, like driving a car or doing skateboarding tricks. Remind adolescents that this "strictness" is normal and usually temporary. This will help them avoid unnecessary conflict as the family recovers. You may say:

Adolescent	When disasters like this happen, parents/caregivers often become more anxious about their kids' safety, so they often have more restrictions. So, while your parents feel the need to keep you on a tighter leash to make sure you are safe, try to give them some slack. This is usually only temporary, and will probably decrease as things start to settle down.

Assist with Developmental Issues

Children, adolescents, adults, and families go through stages of physical, emotional, cognitive, and social development. The many stresses and adversities in the aftermath of a disaster may result in key interruptions, delays, or reversals in development. The loss of anticipated opportunities or achievements can be a major consequence of the disaster. Developmental progression is often measured by these milestones.

Examples of Developmental 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	• buying 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

Assist with Developmental Issues - *continued*

Children and families should also be given an opportunity to attend to the disaster's impact on development. It can be helpful to ask children and families directly:

Parent/Caregiver	Are there any special events that the family was looking forward to? Was anyone about to do something important, like starting school, graduating from high school, or entering college?
Adult	Are there any goals you were working towards that this disaster has, or might interfere with, like a promotion at work or getting married?
Child/Adolescent	Were there things before the disaster that you were looking forward to, like a birthday, a school activity, or playing on a sport team?

You should try to increase the family's appreciation of these issues, so that they understand the challenge to each individual, as well as the whole family. Help find alternative ways for family members to handle the interruption or delay. In helping to develop a plan to address these concerns, consider whether the family can:

- Postpone the event to a later date
- Relocate the event to a different place
- Change expectations, so that the postponement becomes tolerable

Assist with Anger Management

Stressful post-disaster situations can make survivors feel irritable and increase their difficulty in managing their anger. In addressing anger, you can:

- Explain that feelings of anger and frustration are common to survivors after disaster.
- Discuss how the anger is affecting their life (for example, relationship with family members and friends, and parenting).
- Normalize the experience of anger, while discussing how anger can increase interpersonal conflict, push others away, or potentially lead to violence.
- Ask survivors to identify changes that they would like to make to address their anger.
- Compare how holding on to the anger can hurt them, versus how coping with, letting go of anger or directing it toward positive activities can help.
- Emphasize that some anger is normal and even helpful, while too much anger can undermine what they want to do.

Some anger management skills that you can suggest include:

- Take a "time out" or "cool down" (walk away and calm down, do something else for a while).
- Talk to a friend about what is angering you.
- Blow off steam through physical exercise (go for a walk, jog, do pushups).
- Keep a journal in which you describe how you feel and what you can do to change the situation.
- Remind yourself that being angry will not help you achieve what you want, and may harm important relationships.
- Distract yourself with positive activities like reading a book, praying or meditating, listening to upbeat music, going to religious services or other uplifting group activities, helping a friend or someone in need, etc.
- Look at your situation in a different way, see it from another's viewpoint, or find reasons your anger may be over the top.
- For parents/caregivers, have another family member or other adult temporarily supervise your children's activities while you are feeling particularly angry or irritable.
- Children and adolescents often like activities that help them express their feelings, such as drawing pictures, writing in a journal, playing out the situation with toys, and composing a song.
- Help children and adolescents to problem-solve a situation that is angering or frustrating them (like helping them settle a dispute with another child, helping them obtain books or toys, etc.).

If the angry person appears uncontrollable or becomes violent, seek immediate medical/mental health attention and contact security.

Address Highly Negative Emotions (Guilt and Shame)

In the aftermath of disasters, survivors may think about what caused the event, how they reacted, and what the future holds. Attributing excessive blame to themselves or others may add to their distress. You should listen for such negative beliefs, and help survivors to look at the situation in ways that are less upsetting. You might ask:

- How could you look at the situation that would be less upsetting and more helpful? What's another way of thinking about this?

Address Highly Negative Emotions (Guilt and Shame) - *continued*

- How might you respond if a good friend was talking to himself/herself like this? What would you say to him/her? Can you say the same things to yourself?

Tell the survivor that even if he/she thinks he/she is at fault, that does not make it true. If the survivor is receptive, offer some alternative ways of looking at the situation. Help to clarify misunderstandings, rumors, and distortions that exacerbate distress, unwarranted guilt, or shame. For children and adolescents who have difficulty labeling thoughts, you can write the negative thoughts on a piece of paper (for example, "I did something wrong," "I caused it to happen," "I was misbehaving") and have the child add to them. You can then discuss each one, clarify any misunderstandings, discuss more helpful thoughts, and write them down. Remind the child or adolescent that he/she is not at fault, even if he/she has not expressed these concerns.

Help with Sleep Problems

Sleep difficulties are common following a disaster. People tend to stay on alert at night, making it hard to fall asleep and causing frequent awakenings. Worries about adversities and life changes can also make it hard to fall asleep. Disturbance in sleep can have a major effect on mood, concentration, decision-making, and risk for injury. Ask whether the survivor is having any trouble sleeping and about sleep routines and sleep-related habits. Problem-solve ways to improve sleep. For example the survivor might try to:

- Go to sleep at the same time and get up at the same time each day.
- Reduce alcohol consumption, alcohol disrupts sleep.
- Eliminate consumption of caffeinated beverages in the afternoon or evening.
- Increase regular exercise, though not too close to bedtime.
- Relax before bedtime by doing something calming, like listening to soothing music, meditating, or praying.
- Limit daytime naps to 15 minutes and limit napping later than 4 PM.

Discuss that worry over immediate concerns and exposure to daily reminders can make it more difficult to sleep, and that being able to discuss these and get support from others can improve sleep over time.

Remind parents that it is common for children to want to remain close to their parents at nighttime, and even to want to sleep in bed with them. **Temporary changes in sleeping arrangements are okay**, as long as parents make a plan with their children to negotiate a return to normal sleeping arrangements. For example, a parent might say, "We have all been scared by what happened. You can stay in our bedroom for the next couple of nights. Then you will sleep in your bed, but we will sit with you in your bedroom for a while before you go to sleep so you will feel safe. If you get scared again, we can talk about it."

Address Alcohol and Substance Use

When use of alcohol and other substances is a concern:

- Explain to the survivor that many people (including adolescents) who experience stress reactions choose to drink or use medications or drugs to reduce their bad feelings.
- Ask the individual to identify what he/she sees as the positives and negatives of using alcohol or drugs to cope.
- Discuss and mutually agree on abstinence or a safe pattern of use.
- Discuss anticipated difficulties in changing behavior.
- If appropriate and acceptable to the person, make a referral for substance abuse counseling or detoxification.
- If the individual has previously received treatment for substance abuse, encourage him/her to once again seek treatment to get through the next few weeks and months.

The handout, ***Alcohol, Medication, and Drug Use after Disasters*** (Appendix E) gives an overview of this information, and is intended for adults and adolescents with concerns in this area.

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Collaborative Services:

- Provide Direct Link to Additional Needed Services
- Referrals for Children and Adolescents
- Referrals for Older Adults
- Promote Continuity in Helping Relationships

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8. Linkage with Collaborative Services

Goal: To link survivors with available services needed at the time or in the future.

Provide Direct Link to Additional Needed Services

As you provide information, also discuss which of the survivor's needs and current concerns require additional information or services. Do what is necessary to ensure effective linkage with those services (for example, walk the survivor over to an agency representative who can provide a service, set up a meeting with a community representative who may provide appropriate referrals). Examples of situations requiring a referral include:

- An acute medical problem that needs immediate attention
- An acute 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 the use of alcohol or drugs
- Cases involving domestic, child, or elder abuse (be aware of reporting laws)
- When medication is needed for stabilization
- When pastoral counseling is desired
- Ongoing difficulties with coping (4 weeks or more after the disaster)
- Significant developmental concerns about children or adolescents
- When the survivor asks for a referral

In addition, reconnect survivors to agencies that provided them services before the disaster including:

- Mental health services
- Medical services
- Social support services
- Child welfare services
- Schools
- Drug and alcohol support groups

Provide Direct Link to Additional Needed Services - *continued*

When making a referral:

- Summarize your discussion with the person about his/her needs and concerns.
- Check for the accuracy of your summary.
- Describe the option of referral, including how this may help, and what will take place if the individual goes for further help.
- Ask about the survivor's reaction to the suggested referral.
- Give written referral information, or if possible, make an appointment then and there.

Referrals for Children and Adolescents

Remember that children and adolescents under the age of 18 will need parental consent for services outside of immediate emergency care. Youth may be less likely to self-refer when they are experiencing difficulties, and are less likely to follow through on referrals without an adult who is engaged in the process. To maximize the likelihood that youth will follow through with a referral, you should:

- Recommend that any follow-up services for the family include (at least) a brief evaluation of child and adolescent adjustment.
- Make your interactions with children and adolescents positive and supportive to help them develop a positive attitude towards future care providers.
- Remember that children and adolescents have an especially difficult time telling and retelling information related to traumatic events. When working with youth, summarize in writing the basic information about the event that you have gathered and communicate this information to the receiving professional. This will help minimize the number of times that they will have to retell the story of their experiences.

Referrals for Older Adults

Help with plans for an elder who is going home or needs access to alternative housing. Make sure the elder has referral sources for the following, if needed:

- A primary care physician
- A local senior center
- Council on Aging programs
- Social support services

- Meals on Wheels
- Senior housing or assisted living
- Transportation services

Promote Continuity in Helping Relationships

A secondary, but important concern for many survivors is being able to keep in contact with responders who have been helpful. In most cases, continuing contact between survivors and you will not be possible because survivors will leave triage sites or family assistance centers and go to other sites for continuing services. However, loss of contacts made during the acute aftermath of disasters can lead to a sense of abandonment or rejection. You can create a sense of continuing care if you:

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

Sometimes, survivors feel as if they are meeting a never-ending succession of helpers, and that they have to go on explaining their situation and telling their story to each one in turn. To the extent possible, minimize this. If you are leaving a response site, let the survivor know, and if possible, ensure a direct “hand-off” to another provider, one who will be in a position to maintain an ongoing helping relationship with the person. Orient the new provider to what he/she needs to know about the person, and if possible, provide an introduction.

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LIST OF APPENDICES:

Appendix A: Overview of Psychological First Aid

Appendix B: Service Delivery Sites and Settings

Appendix C: Psychological First Aid Provider Care

Appendix D: Psychological First Aid Worksheets

Appendix E: Handouts for Survivors

Appendix F: Position Statement on Psychological Debriefing

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Appendix A:

- Overview of Psychological First Aid

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Overview of Psychological First Aid

	Section Headers
Preparing to Deliver Psychological First Aid	1. Entering the setting 2. Providing services 3. Group settings 4. Maintain a calm presence 5. Be sensitive to culture and diversity 6. Be aware of at-risk populations
Contact and Engagement	1. Introduce yourself/ask about immediate needs 2. Confidentiality
Safety and Comfort	1. Ensure immediate physical safety 2. Provide information about disaster response activities and services 3. Attend to physical comfort 4. Promote social engagement 5. Attend to children who are separated from their parents/caregivers 6. Protect from additional traumatic experiences and trauma reminders 7. Help survivors who have a missing family member 8. Help survivors when a family member or close friend has died 9. Attend to grief and spiritual issues 10. Provide information about casket and funeral issues 11. Attend to issues related to traumatic grief 12. Support survivors who receive death notification 13. Support survivors involved in body identification 14. Help caregivers confirm body identification to a child or adolescent
Stabilization	1. Stabilize emotionally overwhelmed survivors 2. Orient emotionally overwhelmed survivors 3. The role of medications in stabilization
Information Gathering: Current Needs and Concerns	1. Nature and severity of experiences during the disaster 2. Death of a loved one 3. Concerns about immediate post-disaster circumstances and ongoing threat 4. Separations from or concern about the safety of loved ones 5. Physical illness, mental health conditions, and need for medications 6. Losses (home, school, neighborhood, business, personal property, and pets) 7. Extreme feelings of guilt or shame 8. Thoughts about causing harm to self or others 9. Availability of social support 10. Prior alcohol or drug use 11. Prior exposure to trauma and death of loved ones 12. Specific youth, adult, and family concerns over developmental impact

Overview of Psychological First Aid *- continued*

	Section Headers
Practical Assistance	1. Offering practical assistance to children and adolescents 2. Identify the most immediate needs 3. Clarify the need 4. Discuss an action plan 5. Act to address the need
Connection with Social Supports	1. Enhance access to primary support persons (family and significant others) 2. Encourage use of immediately available support persons 3. Discuss support-seeking and giving 4. Special considerations for children and adolescents 5. Modeling support
Information on Coping	1. Provide basic information about stress reactions 2. Review common psychological reactions to traumatic experiences and losses • *Intrusive reactions* • *Avoidance and withdrawal reactions* • *Physical arousal reactions* • *Trauma reminders* • *Loss reminders* • *Change reminders* • *Hardships* • *Grief reactions* • *Traumatic grief reactions* • *Depression* • *Physical reactions* 3. Talking with children about physical and emotional reactions 4. Provide basic information on ways of coping 5. Teach simple relaxation techniques 6. Coping for families 7. Assist with developmental issues 8. Assist with anger management 9. Address highly negative emotions 10. Help with sleep problems 11. Address alcohol and substance use
Linkage with Collaborative Services	1. Provide direct link to additional needed services 2. Referrals for children and adolescents 3. Referrals for older adults 4. Promote continuity in helping relationships

Psychological First Aid

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Appendix B:

- Service Delivery Sites and Settings

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Service Delivery Sites and Settings

Service Site Challenges in Delivering Psychological First Aid

You can face many challenges in delivering services to disaster survivors and disaster relief workers. These challenges are often related to the specific disaster characteristics (for example, natural vs. human caused, size, location) and those of the individuals involved (for example, populations of special consideration–those with disabilities, youth, disadvantaged groups, individuals with pre-existing medical or mental health conditions). Other challenges pertain to the multiple settings in which you may be deployed. The following information will be helpful in anticipating and understanding the unique challenges of some disaster-related service sites.

General Population Shelters

When it is determined that a community or area of the community must be evacuated because of dangerous or threatening conditions, General Population Shelters are opened for the temporary housing of individuals. General Population Shelters are usually located in schools, community and recreation centers, or in other large facilities. Shelters usually have limited space for people to sleep, as well as an area for meals to be served. Typical challenges include establishing shelter rules (for example, lights out, regulated use of showers when in limited supply, meal times), addressing the socio-cultural and ethnic issues that arise when bringing diverse populations together, managing public health issues (for example, sanitation, medication dispensing, isolating the sick), and resolving disputes that arise among shelter residents or between shelter residents and staff.

Service Centers

Service Centers may be opened by a local or federal governmental agency or by disaster relief organizations to meet the initial needs of disaster survivors. These centers typically offer assistance with locating temporary housing or providing for the immediate personal needs of disaster survivors, such as food, clothing, and clean-up materials. Depending on the size and magnitude of the disaster, you may encounter large numbers of survivors seeking services, and anger and frustration expressed by survivors in circumstances where there are inadequate supplies.

Community Outreach Teams

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

Family Reception Centers

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

Family Assistance Centers

Family Assistance Centers are commonly opened in the event of a disaster involving mass casualties or fatalities. These centers usually offer a range of services in an effort to meet the needs of individuals under these circumstances. Mental health services, spiritual care, and crime victims' services, as well as the services of law enforcement, the medical examiner, disaster relief agencies, and other local, state, and federal agencies are also offered on site. Family Assistance Centers are usually located away from the immediate disaster site. Family members may request visits to the affected site or memorial services. Therefore, the Family Assistance Centers should be close enough to facilitate those activities.

Points of Dispensing (POD) Centers

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

Phone Banks and Hotlines

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

Emergency First Aid Stations

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

Hospitals and Hospital Emergency Room Settings

During a mass casualty event, survivors who are triaged on site and listed as "immediate" will be brought to a hospital. In addition, many others will self-transport to the hospital wanting to be seen in the Emergency Room. This is likely to create a surge on medical resource capacity. Survivors may arrive in large numbers, many with both psychological and physical reactions.

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

Respite Centers

Respite Centers are locations where first responders can rest and obtain food, clothing, and other basic support services. They are usually opened where prolonged rescue and recovery efforts are necessary. Respite Centers are usually located in close proximity to the direct impact of a disaster. Typical challenges for Psychological First Aid include limited time to interact with responders who are extremely busy and tired, and feel a sense of urgency to continue working.

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Psychological First Aid

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Appendix C:

- Psychological First Aid Provider Care

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Psychological First Aid Provider Care

Providing care and support in the immediate aftermath of disaster can be an enriching professional and personal experience that enhances satisfaction through helping others. It can also be physically and emotionally exhausting. The following sections provide information to consider before, during, and after engaging in disaster relief work.

Before Relief Work

In deciding whether to participate in disaster response, you should consider your comfort level with this type of work and your current health, family, and work circumstances. These considerations should include the following:

Personal Considerations

Assess your comfort level with the various situations you may experience while providing Psychological First Aid:

- Working with individuals who are experiencing intense distress and extreme reactions, including screaming, hysterical crying, anger, or withdrawal
- Working with individuals in non-traditional settings
- Working in a chaotic, unpredictable environment
- Accepting tasks that may not initially be viewed as mental health activities (e.g., distributing water, helping serve meals, sweeping the floor)
- Working in an environment with minimal or no supervision or conversely, micro-managed
- Working with and providing support to individuals from diverse cultures, ethnic groups, developmental levels, and faith backgrounds
- Working in environments where the risk of harm or exposure is not fully known
- Working with individuals who are not receptive to mental health support
- Working with a diverse group of professionals, often with different interaction styles

Health Considerations

Assess your current physical and emotional health status, and any conditions that may influence your ability to work long shifts in disaster settings, including:

- Recent surgeries or medical treatments
- Recent emotional or psychological challenges or problems

Health Considerations - *continued*

- Any significant life changes or losses within the past 6-12 months
- Earlier losses or other negative life events
- Dietary restrictions that would impede your work
- Ability to remain active for long periods of time and endure physically exhausting conditions
- If needed, enough medication available for the total length of your assignment plus some extra days

Family Considerations

Assess your family's ability to cope with your providing Psychological First Aid in a disaster setting:

- Is your family prepared for your absence, which may span days or weeks?
- Is your family prepared for you to work in environments where the risk of harm or exposure to harm is not fully known?
- Will your support system (family/friends) assume some of your family responsibilities and duties while you are away or working long hours?
- Do you have any unresolved family/relationship issues that will make it challenging for you to focus on disaster-related responsibilities?
- Do you have a strong, supportive environment to return to after your disaster assignment?

Work Considerations

Assess how taking time off to provide Psychological First Aid might affect your work life:

- Is your employer supportive of your interest and participation in Psychological First Aid?
- Will your employer allow "leave" time from your job?
- Will your employer require you to utilize vacation time or "absence-without-pay time" to respond as a disaster mental health worker?
- Is your work position flexible enough to allow you to respond to a disaster assignment within 24-48 hours of being contacted?
- Will your co-workers be supportive of your absence and provide a supportive environment upon your return?

Personal, Family, Work Life Plan

If you decide to participate in disaster response, take time to make preparations for the following:

- Family and other household responsibilities
- Pet care responsibilities
- Work responsibilities
- Community activities/responsibilities
- Other responsibilities and concerns

During Relief Work

In providing Psychological First Aid, it is important to recognize common and extreme stress reactions, how organizations can reduce the risk of extreme stress to providers, and how best to take care of yourself during your work.

Common Stress Reactions

Providers may experience a number of stress responses, which are considered common when working with survivors:

- Increase or decrease in activity level
- Difficulties sleeping
- Substance use
- Numbing
- Irritability, anger, and frustration
- Vicarious traumatization in the form of shock, fearfulness, horror, helplessness
- Confusion, lack of attention, and difficulty making decisions
- Physical reactions (headaches, stomachaches, being easily startled)
- Depressive or anxiety symptoms
- Decreased social activities

Extreme Stress Reactions

Providers may experience more serious stress responses that warrant seeking support from a professional or monitoring by a supervisor. These include:

- Compassion stress: helplessness, confusion, isolation
- Compassion fatigue: demoralization, alienation, resignation
- Preoccupation or compulsive re-experiencing of trauma experienced either directly or indirectly
- Attempts to over-control in professional or personal situations
- Withdrawal and isolation
- Preventing feelings by relying on substances, becoming overly preoccupied by work, or drastic changes in sleep (avoidance of sleep or not wanting to get out of bed)
- Serious difficulties in interpersonal relationships, including domestic violence
- Depression accompanied by hopelessness (which has the potential to place individuals at a higher risk for suicide)
- Unnecessary risk-taking

Organizational Care of Providers

Organizations that recruit providers can reduce the risk of extreme stress by putting supports and policies in place. These include:

- Limiting work shifts to no more than 12 hours and encouraging work breaks
- Rotating of providers from the most highly exposed assignments to lesser levels of exposure
- Mandating time off
- Identifying enough providers at all levels, including administration, supervision, and support
- Encouraging peer partners and peer consultation
- Monitoring providers who meet certain high risk criteria, such as:
  - Survivors of the disaster
  - Those having regular exposure to severely affected individuals or communities
  - Those with pre-existing conditions
  - Those with multiple stresses, including those who have responded to multiple disasters in a short period of time

- Establishing supervision, case conferencing, and staff appreciation events
- Conducting trainings on stress management practices

Provider Self-Care

Activities that promote self-care include:

- Managing personal resources
- Planning for family/home safety, including making child care and pet care plans
- Getting adequate exercise, nutrition, and relaxation
- Using stress management tools regularly, such as:
  - Accessing supervision routinely to share concerns, identifying difficult experiences, and strategizing to solve problems
  - Practicing brief relaxation techniques during the workday
  - Using the buddy system to share upsetting emotional responses
  - Staying aware of limitations and needs
  - Recognizing when one is Hungry, Angry, Lonely or Tired (HALT), and taking the appropriate self-care measures
  - Increasing activities that are positive
  - Practicing religious faith, philosophy, and spirituality
  - Spending time with family and friends
  - Learning how to "put stress away"
  - Writing, drawing, and painting
  - Limiting caffeine, tobacco, and substance use

As much as possible, you should make every effort to:

- Self-monitor and pace your efforts
- Maintain boundaries: delegate, say no, and avoid working with too many survivors in a given shift
- Perform regular check-ins with colleagues, family, and friends
- Work with partners or in teams
- Take relaxation/stress management/bodily care/refreshment breaks
- Utilize regular peer consultation and supervision

Provider Self-Care - ***continued***

- Try to be flexible, patient, and tolerant
- Accept that you cannot change everything

You should avoid engaging in:

- Extended periods of solo work without colleagues
- Working "round the clock" with few breaks
- Negative self-talk that reinforces feelings of inadequacy or incompetency
- Excessive use of food/substances as a support
- Common attitudinal obstacles to self-care:
  - "It would be selfish to take time to rest."
  - "Others are working around the clock, so should I."
  - "The needs of survivors are more important than the needs of helpers."
  - "I can contribute the most by working all the time."
  - "Only I can do x, y, and z."

After Relief Work

Expect a readjustment period upon returning home. You may need to make personal reintegration a priority for a while.

Organizational Care of Providers

Organizations should:

- Encourage time off for providers who have experienced personal trauma or loss.
- Institute exit interviews to help providers with their experience–this should include information about how to communicate with their families about their work.
- Encourage providers to seek counseling when needed, and provide referral information.
- Provide education on stress management.
- Facilitate ways providers can communicate with each other by establishing listservs, sharing contact information, or scheduling conference calls.
- Provide information regarding positive aspects of the work.

Provider Self-Care

Make every effort to:

- Seek out and give social support.
- Check in with other relief colleagues to discuss relief work.
- Increase collegial support.
- Schedule time for a vacation or gradual reintegration into normal life.
- Prepare for worldview changes that may not be mirrored by others in your life.
- Participate in formal help to address your response to relief work if extreme stress persists for greater than two to three weeks.
- Increase leisure activities, stress management, and exercise.
- Pay extra attention to health and nutrition.
- Pay extra attention to rekindling close interpersonal relationships.
- Practice good sleep routines.
- Make time for self-reflection.
- Practice receiving from others.
- Find activities that you enjoy or that make you laugh.
- Try at times not to be in charge or the "expert."
- Increase experiences that have spiritual or philosophical meaning to you.
- Anticipate that you will experience recurring thoughts or dreams, and that they will decrease over time.
- Keep a journal to get worries off your mind.
- Ask help in parenting if you feel irritable or are having difficulties adjusting to being back at home.

Make every effort to avoid:

- Excessive use of alcohol, illicit drugs, or excessive amounts of prescription drugs.
- Making any big life changes for at least a month.
- Negatively assessing your contribution to relief work.
- Worrying about readjusting.

Provider Self-Care - *continued*

- Obstacles to better self-care:
  - Keeping too busy
  - Making helping others more important than self-care
  - Avoiding talk about relief work with others

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Appendix D:

- Psychological First Aid Worksheets

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Provider Worksheets

Survivor Current Needs

Date: _____ Provider: _____

Survivor Name:_____

Location: _____

This session was conducted with (check all that apply):

☐ Child ☐ Adolescent ☐ Adult ☐ Family ☐ Group

Provider: Use this form to document what the survivor needs most at this time. This form can be used to communicate with referral agencies to help promote continuity of care.

1. Check the boxes corresponding to difficulties the survivor is experiencing.

Behavioral	Emotional	Physical	Cognitive
☐ Extreme disorientation ☐ Excessive drug, alcohol, or prescription drug use ☐ Isolation/ withdrawal ☐ High risk behavior ☐ Regressive behavior ☐ Separation anxiety ☐ Violent behavior ☐ Maladaptive coping ☐ Other _____	☐ Acute stress reactions ☐ Acute grief reactions ☐ Sadness, tearfulness ☐ Irritability, anger ☐ Feeling anxious, fearful ☐ Despair, hopelessness ☐ Feelings of guilt or shame ☐ Feeling emotionally numb, disconnected ☐ Other _____	☐ Headaches ☐ Stomachaches ☐ Sleep difficulties ☐ Difficulty eating ☐ Worsening of health conditions ☐ Fatigue/exhaustion ☐ Chronic agitation ☐ Other _____	☐ Inability to accept/ cope with death of loved one(s) ☐ Distressing dreams or nightmares ☐ Intrusive thoughts or images ☐ Difficulty concentrating ☐ Difficulty remembering ☐ Difficulty making decisions ☐ Preoccupation with death/destruction ☐ Other _____

2. Check the boxes corresponding to difficulties the survivor is experiencing.

- ☐ Past or preexisting trauma/psychological problems/substance abuse problems
- ☐ Injured as a result of the disaster
- ☐ At risk of losing life during the disaster
- ☐ Loved one(s) missing or dead
- ☐ Financial concerns
- ☐ Displaced from home
- ☐ Living arrangements
- ☐ Lost job or school
- ☐ Assisted with rescue/recovery
- ☐ Has physical/emotional disability
- ☐ Medication stabilization
- ☐ Concerns about child/adolescent
- ☐ Spiritual concerns
- ☐ Other: _____

3. Please make note of any other information that might be helpful in making a referral.

_____

_____

4. Referral

- ☐ Within project (specify) _____
- ☐ Other disaster agencies
- ☐ Professional mental health services
- ☐ Medical treatment
- ☐ Substance abuse treatment
- ☐ Other community services
- ☐ Clergy
- ☐ Other: _____

5. Was the referral accepted by the individual?

- ☐ Yes
- ☐ No

Provider Worksheets

Psychological First Aid Components Provided

Date: _____ Provider: _____

Location: _____

This session was conducted with (check all that apply):

☐ Child ☐ Adolescent ☐ Adult ☐ Family ☐ Group

Place a checkmark in the box next to each component of Psychological First Aid that you provided in this session.

Contact and Engagement

☐ Initiated contact in an appropriate manner
☐ Asked about immediate needs

Safety and Comfort

☐ Took steps to ensure immediate physical safety
☐ Gave information about the disaster/risks
☐ Attended to physical comfort
☐ Encouraged social engagement
☐ Attended to a child separated from parents
☐ Protected from additional trauma
☐ Assisted with concern over missing loved one
☐ Assisted after death of loved one
☐ Assisted with acute grief reactions
☐ Helped with talking to children about death
☐ Attended to spiritual issues regarding death
☐ Attended to traumatic grief
☐ Provided information about funeral issues
☐ Helped survivor after body identification
☐ Helped survivors regarding death notification
☐ Helped with confirmation of death to child

Stabilization

☐ Helped with stabilization
☐ Used grounding technique
☐ Gathered information for medication referral for stabilization

Information Gathering

☐ Nature and severity of disaster experiences
☐ Death of a family member or friend
☐ Concerns about ongoing threat
☐ Concerns about safety of loved one(s)
☐ Physical/mental illness and medications(s)
☐ Disaster-related losses
☐ Extreme guilt or shame
☐ Thoughts of harming self or others
☐ Availability of social support
☐ Prior alcohol or drug use
☐ History of prior trauma and loss
☐ Concerns over developmental impact
☐ Other _____

Practical Assistance

- ☐ Helped to identify most immediate need(s)
- ☐ Helped to clarify need(s)
- ☐ Helped to develop an action plan
- ☐ Helped with action to address the need

Connection with Social Supports

- ☐ Facilitated access to primary support persons
- ☐ Discussed support seeking and giving
- ☐ Modeled supportive behavior
- ☐ Engaged youth in activities
- ☐ Helped problem-solve obtaining/giving social support

Information of Coping

- ☐ Gave basic information about stress reactions
- ☐ Gave basic information on coping
- ☐ Taught simple relaxation techniques(s)
- ☐ Helped with family coping issues
- ☐ Assisted with developmental concerns
- ☐ Assisted with anger management
- ☐ Addressed negative emotions (shame/guilt)
- ☐ Helped with sleep problems
- ☐ Addressed substance abuse problems

Linkage with Collaborative Services

- ☐ Provided link to additional service(s) _____
- ☐ Promoted continuity of care _____
- ☐ Provided handout(s) _____

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Appendix E:

- Handouts for Survivors
  - Connecting with Others: Seeking Social Support (for adults and adolescents)
  - Connecting with Others: Giving Social Support (for adults and adolescents)
  - When Terrible Things Happen (for adults and adolescents)
  - Parent Tips for Helping Infants and Toddlers (for parents/caregivers)
  - Parent Tips for Helping Preschool-Age Children (for parents/caregivers)
  - Parent Tips for Helping School-Age Children (for parents/caregivers)
  - Parent Tips for Helping Adolescents (for parents/caregivers)
  - Tips for Adults (for adult survivors)
  - Basic Relaxation Techniques (for adults, adolescents, and children)
  - Alcohol and Drug Use after Disasters (for adults and adolescents)

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Connecting with Others

Seeking Social Support

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

Social Support Options

- Spouse/partner or parents
- Trusted family member
- Close friend
- Clergy
- Doctor or nurse
- Crisis/School counselor or other counselor
- Support group
- Co-worker/Teacher/Coach
- Pet

Do . . .

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

Don't . . .

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

Ways to Get Connected

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

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Connecting with Others

Giving Social Support

You can help family members and friends cope with the disaster by spending time with them and listening carefully. Most people recover better when they feel connected to others who care about them. Some people choose not to talk about their experiences very much, and others may need to discuss their experiences. For some, talking about things that happened because of the disaster can help those events seem less overwhelming. For others, just spending time with people they feel close to and accepted by, without having to talk, can feel best. Here is some information about giving social support to other people.

Reasons Why People May Avoid Social Support

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

Good Ways to Give Support

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

Behaviors That Interfere with Giving Support

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

When Your Support is Not Enough

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

When Terrible Things Happen - What You May Experience

Immediate Reactions

There are a wide variety of positive and negative reactions that survivors can experience during and immediately after a disaster. These include:

Domain	Negative Responses	Positive Responses
Cognitive	Confusion, disorientation, worry, intrusive thoughts and images, self-blame	Determination and resolve, sharper perception, courage, optimism, faith
Emotional	Shock, sorrow, grief, sadness, fear, anger, numb, irritability, guilt and shame	Feeling involved, challenged, mobilized
Social	Extreme withdrawal, interpersonal conflict	Social connectedness, altruistic helping behaviors
Physiological	Fatigue, headache, muscle tension, stomachache, increased heart rate, exaggerated startle response, difficulties sleeping	Alertness, readiness to respond, increased energy

Common negative reactions that may continue include:

Intrusive reactions

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

Avoidance and withdrawal reactions

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

Physical arousal reactions

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

Reactions to trauma and loss reminders

- Reactions to places, people, sights, sounds, smells, and feelings that are reminders of the disaster
- Reminders can bring on distressing mental images, thoughts, and emotional/physical reactions
- Common examples include sudden loud noises, sirens, locations where the disaster occurred, seeing people with disabilities, funerals, anniversaries of the disaster, and television/radio news about the disaster

Positive changes in priorities, worldview, and expectations

- Enhanced appreciation that family and friends are precious and important
- Meeting the challenge of addressing difficulties (by taking positive action steps, changing the focus of thoughts, using humor, acceptance)
- Shifting expectations about what to expect from day to day and about what is considered a "good day"
- Shifting priorities to focus more on quality time with family or friends
- Increased commitment to self, family, friends, and spiritual/religious faith

When a Loved One Dies, Common Reactions Include:

- Feeling confused, numb, disbelief, bewildered, or lost
- Feeling angry at the person who died or at people considered responsible for the death
- Strong physical reactions such as nausea, fatigue, shakiness, and muscle weakness
- Feeling guilty for still being alive

- Intense emotions such as extreme sadness, anger, or fear
- Increased risk for physical illness and injury
- Decreased productivity or difficulty making decisions
- Having thoughts about the person who died, even when you don't want to
- Longing, missing, and wanting to search for the person who died
- Children are particularly likely to worry that they or a parent might die
- Children may become anxious when separated from caregivers or other loved ones

What Helps

- Talking to another person for support or spending time with others
- Engaging in positive distracting activities (sports, hobbies, reading)
- Getting adequate rest and eating healthy meals
- Trying to maintain a normal schedule
- Scheduling pleasant activities
- Taking breaks
- Reminiscing about a loved one who has died
- Focusing on something practical that you can do right now to manage the situation better
- Using relaxation methods (breathing exercises, meditation, calming self-talk, soothing music)
- Participating in a support group
- Exercising in moderation
- Keeping a journal
- Seeking counseling

What Doesn't Help

- Using alcohol or drugs to cope
- Extreme avoidance of thinking or talking about the event or a death of a loved one
- Violence or conflict
- Overeating or failing to eat
- Excessive TV or computer games
- Blaming others
- Working too much
- Extreme withdrawal from family or friends
- Not taking care of yourself
- Doing risky things (driving recklessly, substance abuse, not taking adequate precautions)
- Withdrawing from pleasant activities

Parent Tips for Helping Infants and Toddlers after Disasters

If Your Child	Understand	Ways to Help
. . has problems sleeping, doesn't want to go to bed, won't sleep alone, wakes up at night screaming.	▪ When children are scared, they want to be with people who help them feel safe, and they worry when you are not together. ▪ If you were separated during the disaster, going to bed alone may remind your child of that separation. ▪ Bedtime is a time for remembering because we are not busy doing other things. Children often dream about things they fear and can be scared of going to sleep.	▪ If you want, let your child sleep with you. Let him know this is just for now. ▪ Have a bedtime routine: a story, a prayer, cuddle time. Tell him the routine (every day), so he knows what to expect. ▪ Hold him and tell him that he is safe, that you are there and will not leave. Understand that he is not being difficult on purpose. This may take time, but when he feels safer, he will sleep better.
. . worries something bad will happen to you. (You may also have worries like this.)	▪ It is natural to have fears like this after being in danger. ▪ These fears may be even stronger if your child was separated from loved ones during the disaster.	▪ Remind your child and yourself that right now you are safe. ▪ If you are not safe, talk about how you are working to keep her safe. ▪ Make a plan for who would care for your child if something did happen to you. This may help you worry less. ▪ Do positive activities together to help her think about other things.
. . cries or complains whenever you leave him, even when you go to the bathroom. . . can't stand to be away from you.	▪ Children who cannot yet speak or say how they feel may show their fear by clinging or crying. ▪ Goodbyes may remind your child of any separation you had related to the disaster. ▪ Children's bodies react to separations (stomach sinks, heart beats faster). Something inside says, "Oh no, I can't lose her." ▪ Your child is not trying to manipulate or control you. He is scared. ▪ He may also get scared when other people (not just you) leave. Goodbyes make him scared.	▪ Try to stay with your child and avoid separations right now. ▪ For brief separations (store, bathroom), help your child by naming his feelings and linking them to what he has been through. Let him know you love him and that this goodbye is different, you'll be back soon. "You're so scared. You don't want me to go because last time I was gone you didn't know where I was. This is different, and I'll be right back." ▪ For longer separations, have him stay with familiar people, tell him where you are going and why, and when you will come back. Let him know you will think about him. Leave a photo or something of yours and call if you can. When you come back, tell him you missed him, thought about him, and did come back. You will need to say this over and over.
. . has problems eating, eats too much or refuses food.	▪ Stress affects your child in different ways, including her appetite. ▪ Eating healthfully is important, but focusing too much on eating can cause stress and tension in your relationship.	▪ Relax. Usually, as your child's level of stress goes down, her eating habits will return to normal. Don't force your child to eat. ▪ Eat together and make meal times fun and relaxing. ▪ Keep healthy snacks around. Young children often eat on the go. ▪ If you are worried, or if your child loses a significant amount of weight, consult a pediatrician.

Parent Tips for Helping Infants and Toddlers after Disasters

If Your Child	Understand	Ways to Help
. . is not able to do things he used to do (like use the potty). . . does not talk like he used to.	▪ Often when young children are stressed or scared, they temporarily lose abilities or skills they recently learned. ▪ This is the way young children tell us that they are not okay and need our help. ▪ Losing an ability after children have gained it (like starting to wet the bed again) can make them feel ashamed or embarrassed. Caregivers should be understanding and supportive. ▪ Your child is not doing this on purpose.	▪ Avoid criticism. It makes him worried that he'll never learn. ▪ Do not force your child. It creates a power struggle. ▪ Instead of focusing on the ability (like not using the potty), help your child feel understood, accepted, loved, and supported. ▪ As your child feels safer, he will recover the ability he lost.
. . is reckless, does dangerous things.	▪ It may seem strange, but when children feel unsafe, they often behave in unsafe ways. ▪ It is one way of saying, "I need you. Show me I'm important by keeping me safe."	▪ Keep her safe. Calmly go and get her and hold her if necessary. ▪ Let her know that what she is doing is unsafe, that she is important, and you wouldn't want anything to happen to her. ▪ Show her other more positive ways that she can have your attention.
. . is scared by things that did not scare her before.	▪ Young children believe their parents are all-powerful and can protect them from anything. This belief helps them feel safe. ▪ Because of what happened, this belief has been damaged, and without it, the world is a scarier place. ▪ Many things may remind your child of the disaster (rain, aftershocks, ambulances, people yelling, a scared look on your face), and will scare her. ▪ It is not your fault–it was the disaster.	▪ When your child is scared, talk to her about how you will keep her safe. ▪ If things remind your child of the disaster and cause her to worry that it is happening again, help her understand how what is happening now (like rain or aftershocks) is different from the disaster. ▪ If she talks about monsters, join her in chasing them out. "Go away, monster. Don't bother my baby. I'm going to tell the monster boo, and it will get scared and go away. Boo, boo." ▪ Your child is too young to understand and recognize how you did protect her, but remind yourself of the good things you did.
. . seems "hyper," can't sit still, and doesn't pay attention to anything.	▪ Fear can create nervous energy that stays in our bodies. ▪ Adults sometimes pace when worried. Young children run, jump, and fidget. ▪ When our minds are stuck on bad things, it is hard to pay attention to other things. ▪ Some children are naturally active.	▪ Help your child to recognize his feelings (fear, worry) and reassure your child that he is safe. ▪ Help your child get rid of nervous energy (stretching, running, sports, breathing deep and slow). ▪ Sit with him and do an activity you both enjoy (throw a ball, read books, play, draw). Even if he doesn't stop running around, this helps him. ▪ If your child is naturally active, focus on the positive. Think of all the energy he has to get things done, and find activities that fit his needs.
. . plays in a violent way. . . keeps talking about the disaster and the bad things he saw.	▪ Young children often talk through play. Violent play can be their way of telling us how crazy things were or are, and how they feel inside. ▪ When your child talks about what happened, strong feelings may come up both for you and your child (fear, sadness, anger).	▪ If you can tolerate it, listen to your child when he "talks." ▪ As your child plays, notice the feelings he has and help him by naming feelings and being there to support him (hold him, soothe him). ▪ If he gets overly upset, spaces out, or he plays out the same upsetting scene, help him calm down, help him feel safe, and consider getting professional help.

Parent Tips for Helping Infants and Toddlers after Disasters

If Your Child	Understand	Ways to Help
. .is now very demanding and controlling. . . seems "stubborn" insisting that things be done her way.	▪ Between the age of 18 months to 3 years, young children often seem "controlling." ▪ It can be annoying, but it is a normal part of growing up and helps them learn that they are important and can make things happen. ▪ When children feel unsafe, they may become more controlling than usual. This is one way of dealing with fears. They are saying, "Things are so crazy I need control over something."	▪ Remember your child is not controlling or bad. This is normal, but may be worse right now because she feels unsafe. ▪ Let your child have control over small things. Give her choices over what she wears or eats, games you play, stories you read. If she has control over small things, it can make her feel better. Balance giving her choices and control with giving her structure and routines. She will feel unsafe if she "runs the show." ▪ Cheer her on as she tries new things. She can also feel more in control when she can put her shoes on, put a puzzle together, pour juice.
. . tantrums and is cranky. . .yells a lot – more than usual.	▪ Even before the disaster, your child may have had tantrums. They are a normal part of being little. It's frustrating when you can't do things and when you don't have the words to say what you want or need. ▪ Now, your child has a lot to be upset about (just like you) and may really need to cry and yell.	▪ Let him know you understand how hard this is for him. "Thing are really bad right now. It's been so scary. We don't have your toys or TV, and you're mad." ▪ Tolerate tantrums more than you usually would, and respond with love rather than discipline. You might not normally do this, but things are not normal. If he cries or yells, stay with him and let him know you are there for him. Reasonable limits should be set if tantrums become frequent or are extreme.
. . hits you.	▪ For children, hitting is a way of expressing anger. ▪ When children can hit adults they feel unsafe. It's scary to be able to hit someone who's supposed to protect you. ▪ Hitting can also come from seeing other people hit each other.	▪ Each time your child hits, let her know that this is not okay. Hold her hands, so she can't hit, have her sit down. Say something like, "It's not okay to hit, it's not safe. When you hit, you are going to need to sit down." ▪ If she is old enough, give her the words to use or tell her what she needs to do. Tell her, "Use your words. Say, I want that toy." ▪ Help her express anger in other ways (play, talk, draw). ▪ If you are having conflict with other adults, try to work it out in private, away from where your child can see or hear you. If needed, talk with a friend or professional about your feelings.
. . says "Go away, I hate you!" . . says "This is all your fault."	▪ The real problem is the disaster and everything that followed, but your child is too little to fully understand that. ▪ When things go wrong, young children often get mad at their parents because they believe they should have stopped it from happening. ▪ You are not to blame, but now is not the time to defend yourself. Your child needs you.	▪ Remember what your child has been through. He doesn't mean everything he is saying; he's angry and dealing with so many difficult feelings. ▪ Support your child's feeling of anger, but gently redirect the anger towards the disaster. "You are really mad. Lots of bad things have happened. I'm mad too. I really wish it didn't happen, but even mommies can't make hurricanes not happen. It's so hard for both of us."

Parent Tips for Helping Infants and Toddlers after Disasters

If Your Child	Understand	Ways to Help
. . doesn't want to play or do anything. . . seems to not really have any feelings (happy or sad).	▪ Your child needs you. So much has happened and he may be feeling sad and overwhelmed. ▪ When children are stressed, some yell and others shut down. Both need their loved ones.	▪ Sit by your child and keep him close. Let him know you care. ▪ If you can, give words to his feelings. Let him know it's okay to feel sad, mad, or worried. "It seems like you don't want to do anything. I wonder if you are sad. It's okay to be sad. I will stay with you." ▪ Try to do things with your child, anything he might like (read a book, sing, play together).
. . cries a lot.	▪ Your family may have experienced difficult changes because of the disaster, and it is natural that your child is sad. ▪ When you let your child feel sad and provide her with comfort, you help your child even if she remains sad. ▪ If you have strong feelings of sadness, it may be good for you to get support. Your child's well-being is connected to your well-being.	▪ Allow your child to express feelings of sadness. ▪ Help your child name her feelings and understand why she may feel that way. "I think you're sad. A lot of hard things have happened" ▪ Support your child by sitting with her and giving her extra attention. Spend special time together. ▪ Help your child feel hopeful about the future. Together think and talk about how your lives will continue and the good things you will do, like go for a walk, go to the park or zoo, play with friends. ▪ Take care of yourself.
. . misses people you are no longer able to see after the disaster.	▪ Even though young children do not always express how they feel, be aware that it is difficult for them when they lose contact with important people. ▪ If someone close to your child died, your child may show stronger reactions to the disaster. ▪ Young children do not understand death, and may think that the person can come back.	▪ For those that have moved away, help your child stay in touch in some way (for example, sending pictures or cards, calling). ▪ Help your child talk about these important people. Even when we are apart from people, we can still have positive feelings about them by remembering and talking about them. ▪ Acknowledge how hard it is to not be able to see people we care for. It is sad. ▪ Where someone has died, answer your child's questions simply and honestly. When strong reactions last longer than two weeks, seek help from a professional.
. . misses things you have lost because of the disaster.	▪ When a disaster brings so much loss to a family and community, it is easy to lose sight of how much the loss of a toy or other important item (blanket) can mean to a child. ▪ Grieving for a toy is also your child's way of grieving for all you had before the disaster.	▪ Allow your child to express feelings of sadness. It is sad that your child lost her toy or blanket. ▪ If possible, try to find something that would replace the toy or blanket that would be acceptable and satisfying to your child. ▪ Distract your child with other activities.

Parent Tips for Helping Preschool-Age Children after Disasters

Reactions/Behavior	Responses	Examples of things to do and say
Helplessness and passivity: Young children know they can't protect themselves. In a disaster, they feel even more helpless. They want to know their parents will keep them safe. They might express this by being unusually quiet or agitated.	▪ Provide comfort, rest, food, water, and opportunities for play and drawing. ▪ Provide ways to turn spontaneous drawing or playing about traumatic events to something that would make them feel safer or better. ▪ Reassure your child that you and other grownups will protect them.	▪ Give your child more hugs, hand holding, or time in your lap. ▪ Make sure there is a special safe area for your child to play with proper supervision. ▪ In play, a four year old keeps having the blocks knocked down by hurricane winds. Asked, "Can you make it safe from the winds?" the child quickly builds a double block thick wall and says, "Winds won't get us now." A parent might respond with, "That wall sure is strong," and explain, "We're doing a lot of things to keep us safe."
General fearfulness: Young children may become more afraid of being alone, being in the bathroom, going to sleep, or otherwise separated from parents. Children want to believe that their parents can protect them in all situations and that other grownups, such as teachers or police officers, are there to help them.	▪ Be as calm as you can with your child. Try not to voice your own fears in front of your child. ▪ Help children regain confidence that you aren't leaving them and that you can protect them. ▪ Remind them that there are people working to keep families safe, and that your family can get more help if you need to. ▪ If you leave, reassure your children you will be back. Tell them a realistic time in words they understand, and be back on time. ▪ Give your child ways to communicate their fears to you.	▪ Be aware when you are on the phone or talking to others, that your child does not overhear you expressing fear. ▪ Say things such as, "We are safe from the earthquake now, and people are working hard to make sure we are okay." ▪ Say, "If you start feeling more scared, come and take my hand. Then I'll know you need to tell me something."
Confusion about the danger being over: Young children can overhear things from adults and older children, or see things on TV, or just imagine that it is happening all over again. They believe the danger is closer to home, even if it happened further away.	▪ Give simple, repeated explanations as needed, even every day. Make sure they understand the words you are using. ▪ Find out what other words or explanations they have heard and clarify inaccuracies. ▪ If you are at some distance from the danger, it is important to tell your child that the danger is not near you.	▪ Continue to explain to your child that the disaster has passed and that you are away from the danger ▪ Draw, or show on a map, how far away you are from the disaster area, and that where you are is safe. "See? The disaster was way over there, and we're way over here in this safe place."
Returning to earlier behaviors: Thumb sucking, bed-wetting, baby-talk, needing to be in your lap.	▪ Remain neutral or matter-of-fact, as best you can, as these earlier behaviors may continue a while after the disaster.	▪ If your child starts bedwetting, change her clothes and linens without comment. Don't let anyone criticize or shame the child.

Parent Tips for Helping Preschool-Age Children after Disasters

Reactions/Behavior	Responses	Examples of things to do and say
Fears the disaster will return: When having reminders—seeing, hearing, or otherwise sensing something that reminds them of the disaster.	▪ Explain the difference between the event and reminders of the event. ▪ Protect children from things that will remind them as best you can.	▪ "Even though it's raining, that doesn't mean the hurricane is happening again. A rainstorm is smaller and can't wreck stuff like a hurricane can." ▪ Keep your child from television, radio, and computer stories of the disaster that can trigger fears of it happening again.
Not talking: Being silent or having difficulty saying what is bothering them.	▪ Put common feelings into words, such as anger, sadness, and worry about the safety of parents, friends, and siblings. ▪ Do not force them to talk, but let them know they can talk to you any time.	▪ Draw simple "happy faces" for different feelings on paper plates. Tell a brief story about each one, such as, "Remember when the water came into the house and you had a worried face like this?" ▪ Say something like, "Children can feel really sad when their home is damaged." ▪ Provide art or play materials to help them express themselves. Then use feeling words to check out how they felt. "This is a really scary picture. Were you scared when you saw the water?"
Sleep problems: Fear of being alone at night, sleeping alone, waking up afraid, having bad dreams.	▪ Reassure your child that he is safe. Spend extra quiet time together at bedtime. ▪ Let the child sleep with a dim light on or sleep with you for a limited time. ▪ Some might need an explanation of the difference between dreams and real life.	▪ Provide calming activities before bedtime. Tell a favorite story with a comforting theme. ▪ At bedtime say, "You can sleep with us tonight, but tomorrow you'll sleep in your own bed." ▪ "Bad dreams come from our thoughts inside about being scared, not from real things happening."
Not understanding about death: Preschool age children don't understand that death is not reversible. They have "magical thinking" and might believe their thoughts caused the death. The loss of a pet may be very hard on a child.	▪ Give an age-appropriate consistent explanation–that does not give false hopes–about the reality of death. ▪ Don't minimize feelings over a loss of a pet or a special toy. ▪ Take cues from what your child seems to want to know. Answer simply and ask if he has any more questions.	▪ Allow children to participate in cultural and religious grieving rituals. ▪ Help them find their own way to say goodbye by drawing a happy memory or lighting a candle or saying a prayer for the deceased. ▪ "No, Pepper won't be back, but we can think about him and talk about him and remember what a silly doggy he was." ▪ "The firefighter said no one could save Pepper and it wasn't your fault. I know you miss him very much."

Parent Tips for Helping School-Age Children after Disasters

Reactions	Responses	Examples of things to do and say
Confusion about what happened	▪ Give clear explanations of what happened whenever your child asks. Avoid details that would scare your child. Correct any misinformation that your child has about whether there is a present danger. ▪ Remind children that there are people working to keep families safe and that your family can get more help if needed. ▪ Let your children know what they can expect to happen next.	▪ "I know other kids said that more tornadoes are coming, but we are now in a safe place." ▪ Continue to answer questions your children have (without getting irritable) and to reassure them the family is safe. ▪ Tell them what's happening, especially about issues regarding school and where they will be living.
Feelings of being responsible: School-age children may have concerns that they were somehow at fault, or should have been able to change what happened. They may hesitate to voice their concerns in front of others.	▪ Provide opportunities for children to voice their concerns to you. ▪ Offer reassurance and tell them why it was not their fault.	▪ Take your child aside. Explain that, "After a disaster like this, lots of kids–and parents too–keep thinking, 'What could I have done differently?' or 'I should have been able to do something.' That doesn't mean they were at fault." ▪ "Remember? The firefighter said no one could save Pepper and it wasn't your fault."
Fears of recurrence of the event and reactions to reminders	▪ Help identify different reminders (people, places, sounds, smells, feelings, time of day) and clarify the difference between the event and the reminders that occur after it. ▪ Reassure them, as often as they need, that they are safe. ▪ Protect children from seeing media coverage of the event, as it can trigger fears of the disaster happening again.	▪ When they recognize that they are being reminded, say, "Try to think to yourself, I am upset because I am being reminded of the hurricane because it is raining, but now there is no hurricane and I am safe." ▪ "I think we need to take a break from the TV right now." ▪ Try to sit with your child while watching TV. Ask your child to describe what they saw on the news. Clarify any misunderstandings.
Retelling the event or playing out the event over and over	▪ Permit the child to talk and act out these reactions. Let him know that this is normal. ▪ Encourage positive problem-solving in play or drawing.	▪ "You're drawing a lot of pictures of what happened. Did you know that many children do that?" ▪ "It might help to draw about how you would like your school to be rebuilt to make it safer."

Parent Tips for Helping School-Age Children after Disasters

Reactions	Responses	Examples of things to do and say
Fear of being overwhelmed by their feelings	▪ Provide a safe place for her to express her fears, anger, sadness, etc. Allow children to cry or be sad; don't expect them to be brave or tough.	▪ "When scary things happen, people have strong feelings, like being mad at everyone or being very sad. Would you like to sit here with a blanket until you're feeling better?"
Sleep problems: Bad dreams, fear of sleeping alone, demanding to sleep with parents.	▪ Let your child tell you about the bad dream. Explain that bad dreams are normal and they will go away. Do not ask the child to go into too many details of the bad dream. ▪ Temporary sleeping arrangements are okay; make a plan with your child to return to normal sleeping habits.	▪ "That was a scary dream. Let's think about some good things you can dream about and I'll rub your back until you fall asleep." ▪ "You can stay in our bedroom for the next couple of nights. After that we will spend more time with you in your bed before you go to sleep. If you get scared again, we can talk about it."
Concerns about the safety of themselves and others.	▪ Help them to share their worries and give them realistic information.	▪ Create a "worry box" where children can write out their worries and place them in the box. Set a time to look these over, problem-solve, and come up with answers to the worries.
Altered behavior: Unusually aggressive or restless behavior.	▪ Encourage the child to engage in recreational activities and exercise as an outlet for feelings and frustration.	▪ "I know you didn't mean to slam that door. It must be hard to feel so angry." ▪ "How about if we take a walk? Sometimes getting our bodies moving helps with strong feelings."
Somatic complaints: Headaches, stomachaches, muscle aches for which there seem to be no reason.	▪ Find out if there is a medical reason. If not, provide comfort and assurance that this is normal. ▪ Be matter-of-fact with your child; giving these complaints too much attention may increase them.	▪ Make sure the child gets enough sleep, eats well, drinks plenty of water, and gets enough exercise. ▪ "How about sitting over there? When you feel better, let me know and we can play cards."
Closely watching a parent's responses and recovery: Not wanting to disturb a parent with their own worries.	▪ Give children opportunities to talk about their feelings, as well as your own. ▪ Remain as calm as you can, so as not to increase your child's worries.	▪ "Yes, my ankle is broken, but it feels better since the paramedics wrapped it. I bet it was scary seeing me hurt, wasn't it?"
Concern for other survivors and families.	▪ Encourage constructive activities on behalf of others, but do not burden them with undue responsibility.	▪ Help children identify projects that are age-appropriate and meaningful (clearing rubble from school grounds, collecting money or supplies for those in need).

Parent Tips for Helping Adolescents after Disasters

Reactions	Responses	Examples of things to do and say
Detachment, shame, and guilt	▪ Provide a safe time to discuss with your teen the events and their feelings. ▪ Emphasize that these feelings are common, and correct excessive self-blame with realistic explanations of what actually could have been done.	▪ "Many teens–and adults–feel like you do, angry and blaming themselves that they could have done more. You're not at fault. Remember even the firefighters said there was nothing more we could have done."
Self-consciousness: About their fears, sense of vulnerability, fear of being labeled abnormal.	▪ Help teens understand that these feelings are common. ▪ Encourage relationships with family and peers for needed support during the recovery period.	▪ "I was feeling the same thing. Scared and helpless. Most people feel like this when a disaster happens, even if they look calm on the outside." ▪ "My cell phone is working again, why don't you see if you can get a hold of Pete to see how he's doing." ▪ "And thanks for playing the game with your little sister. She's much better now."
Acting out behavior: Using alcohol or drugs, sexually acting out, accident-prone behavior.	▪ Help teens understand that acting out behavior is a dangerous way to express strong feelings (like anger) over what happened. ▪ Limit access to alcohol and drugs. ▪ Talk about the danger of high-risk sexual activity. ▪ On a time-limited basis, keep a closer watch on where they are going and what they are planning to do.	▪ "Many teens–and some adults–feel out of control and angry after a disaster like this. They think drinking or taking drugs will help somehow. It's very normal to feel that way–but it's not a good idea to act on it." ▪ "It's important during these times that I know where you are and how to contact you." Assure them that this extra checking-in is temporary, just until things have stabilized.
Fears of recurrence and reactions to reminders	▪ Help to identify different reminders (people, places, sounds, smells, feelings, time of day) and to clarify the difference between the event and the reminders that occur after it. ▪ Explain to teens that media coverage of the disaster can trigger fears of it happening again.	▪ "When you're reminded, you might try saying to yourself, 'I am upset now because I am being reminded, but it is different now because there is no hurricane and I am safe.'" ▪ Suggest, "Watching the news reports could make it worse, because they are playing the same images over and over. How about turning it off now?"

Parent Tips for Helping Adolescents after Disasters

Reactions	Responses	Examples of things to do and say
Abrupt shifts in interpersonal relationships: Teens may pull away from parents, family, and even from peers; they may respond strongly to parent's reactions in the crisis.	▪ Explain that the strain on relationships is expectable. Emphasize that everyone needs family and friends for support during the recovery period. ▪ Encourage tolerance for different family members' courses of recovery. ▪ Accept responsibility for your own feelings.	▪ Spend more time talking as a family about how everyone is doing. Say, "You know, the fact that we're crabby with each other is completely normal, given what we've been through. I think we're handling things amazingly. It's a good thing we have each other." ▪ You might say, "I appreciate your being calm when your brother was screaming last night. I know he woke you up, too." ▪ "I want to apologize for being irritable with you yesterday. I am going to work harder to stay calm myself."
Radical changes in attitude	▪ Explain that changes in people's attitudes after a disaster are common, but often return back over time.	▪ "We are all under great stress. When people's lives are disrupted this way, we all feel more scared, angry–even full of revenge. It might not seem like it, but we all will feel better when we get back to a more structured routine."
Premature entrance into adulthood: (wanting to leave school, get married).	▪ Encourage postponing major life decisions. Find other ways to make the teens feel more in control.	▪ "I know you're thinking about quitting school and getting a job to help out. But it's important not to make big decisions right now. A crisis time is not a great time to make major changes."
Concern for other survivors and families	▪ Encourage constructive activities on behalf of others, but do not let them burden themselves with undue responsibility.	▪ Help teens to identify projects that are age-appropriate and meaningful (clearing rubble from school grounds, collecting money or supplies for those in need).

Tips for Adults

Reactions/Behavior	Responses	Examples of things to do and say
High anxiety/arousal: Tension and anxiety are common after disasters. Adults may be excessively worried about the future, have difficulties sleeping, problems concentrating, and feel jumpy and nervous. These reactions can include rapid heart beat and sweating.	▪ Use breathing and/or other relaxation skills. ▪ Take time during the day to calm yourself through relaxation exercises. These can make it easier to sleep, concentrate, and will give you energy.	▪ Breathing exercise: Inhale slowly through your nose and comfortably fill your lungs all the way down to your stomach, while saying to yourself, "My body is filled with calm." Exhale slowly through your mouth and empty your lungs, while silently saying to yourself, "My body is letting go." Do this five times slowly, and as many times a day as needed.
Concern or shame over your own reactions. Many people have strong reactions after a disaster, including fear and anxiety, difficulty concentrating, shame about how they reacted, and feeling guilty about something. It is expectable and understandable to feel many emotions in the aftermath of an extremely difficult event.	▪ Find a good time to discuss your reactions with a family member or trusted friend. ▪ Remember that these reactions are common and it takes time for them to subside. ▪ Correct excessive self-blame with realistic assessment of what actually could have been done.	▪ When talking with someone, find the right time and place, and ask if it is okay to talk about your feelings. ▪ Remind yourself that your feelings are expectable and you are not "going crazy," and that you are not at fault for the disaster. ▪ If these feelings persist for a month or more, you may wish to seek professional help.
Feeling overwhelmed by tasks that need to be accomplished (housing, food, paperwork for insurance, child care, parenting).	▪ Identify what your top priorities are. ▪ Find out what services are available to help get your needs met. ▪ Make a plan that breaks down the tasks into manageable steps.	▪ Make a list of your concerns and decide what to tackle first. Take one step at a time. ▪ Find out which agencies can help with your needs and how to access them. ▪ Where appropriate, rely on your family, friends, and community for practical assistance.
Fears of recurrence and reactions to reminders: It is common for survivors to fear that another disaster will occur, and to react to things that are reminders of what happened.	▪ Be aware that reminders can include people, places, sounds, smells, feelings, time of day. ▪ Remember that media coverage of the disaster can be a reminder and trigger fears of it happening again.	▪ When you are reminded, try saying to yourself, "I am upset because I am being reminded of the disaster, but it is different now because the disaster is not happening and I am safe." ▪ Limit your viewing of news reports so you just get the information that you need.
Changes in attitude, view of the world and of oneself: Strong changes in people's attitudes after a disaster are common, including questioning one's spiritual beliefs, trust in others and social agencies, and concerns about one's own effectiveness, and dedication to helping others.	▪ Postpone any major unnecessary life changes in the immediate future. ▪ Remember that dealing with post-disaster difficulties increases your sense of courage and effectiveness. ▪ Get involved with community recovery efforts.	▪ Getting back to a more structured routine can help improve decision-making. ▪ Remind yourself that going through a disaster can have positive effects on what you value and how you spend your time.

Reactions/Behavior	Responses	Examples of things to do and say
Using alcohol and drugs, or engaging in gambling or high-risk sexual behaviors: Many people feel out of control, scared, hopeless, or angry after a disaster and engage in these behaviors to feel better. This can especially be a problem if there was pre-existing substance abuse or addiction.	▪ Understand that using substances and engaging in addictive behaviors can be a dangerous way to cope with what happened. ▪ Get information about local support agencies.	▪ Remember that substance use and other addictive behaviors can lead to problems with sleep, relationships, jobs, and physical health.
Shifts in interpersonal relationships: People may feel differently towards family and friends; for example, they may feel overprotective and very concerned for each other's safety, frustrated by the reactions of a family member or friend, or they may feel like pulling away from family and friends.	▪ Understand that family and friends are a major form of support during the recovery period. ▪ It is important to understand and tolerate different courses of recovery among family members. ▪ Rely on other family members for help with parenting or other daily activities when you are upset or under stress.	▪ Don't withdraw from others because you feel you might burden them. Most people do better after disasters turning to others. ▪ Ask your friends and family how they are doing, rather than just giving advice, or telling them to "get over it." Offer a supportive ear or lend a helping hand. ▪ Say, "We're crabby with each other and that is completely normal, given what we've been through. I think we're handling things amazingly. It's a good thing we have each other."
Excessive anger: Some degree of anger is understandable and expected after a disaster, especially when something feels unfair. However, when it leads to violent behavior, extreme anger is a serious problem.	▪ Find ways to manage your anger that help you rather than hurt you.	▪ Take time to cool down, walk away from stressful situations, talk to a friend about what is making you angry, get physical exercise, distract yourself with positive activities, or problem-solve the situation that is making you angry. ▪ Remind yourself that being angry may harm important relationships. ▪ If you become violent, get immediate help.
Sleep difficulties: Trouble falling asleep and frequent awakening is common after a disaster, as people are on edge and worried about adversities and life changes.	▪ Make sure you have good sleep routines.	▪ Go to sleep at the same time every day. ▪ Don't have caffeinated drinks in the evening. ▪ Reduce alcohol consumption. ▪ Increase daytime exercise. ▪ Relax before bedtime. ▪ Limit daytime naps to 15 minutes, and do not nap later than 4 pm.

Tips for Relaxation

Tips for Relaxation

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

For Yourself:

1. Inhale slowly (one-thousand one; one-thousand two; one-thousand three) through your nose and comfortably fill your lungs all the way down to your belly.
2. Silently and gently say to yourself, "My body is filled with calmness." Exhale slowly (one-thousand one; one-thousand two; one-thousand three) through your mouth and comfortably empty your lungs all the way down to your stomach.
3. Silently and gently say to yourself, "My body is releasing the tension."
4. Repeat five times slowly and comfortably.
5. Do this as many times a day as needed.

For Children:

Lead a child through a breathing exercise:

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

Make a Game of It:

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

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Alcohol, Medication, and Drug Use after Disaster

Alcohol, Medication, and Drug Use after Disaster

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

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

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

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

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

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Appendix F:

- Position Statement on Psychological Debriefing

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Position Statement on Psychological Debriefing

Medical Reserve Corps
National Disaster Mental Health Work Group
April 2006

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

Recommendation:

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

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

Rationale

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

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

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

There is no convincing evidence that psychological debriefing prevents PTSD or other trauma-related mental disorders.[2]

Some individuals may be harmed by debriefing, with the "systemic ventilation of feelings" as the potentially most harmful phase.[3]

An individual sense of control or mastery is important in (one's) recovery.[4]

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

Background

The Medical Reserve Corps (MRC), as one of the newest organizations in the disaster response community, has evolved rapidly since its creation in 2002 by the Office of the Surgeon General, United States Public Health Service (USPHS). With more than 400 individual units and over 70,000 members, MRCs have become a prominent vehicle for pre-registering, credentialing and training health (and mental health) professional volunteers in disaster response.

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

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

- Establishing professional core competencies to insure a consistent, well-trained workforce
- Identifying existing training curricula or developing new curricula that embrace these competencies
- Identifying and resolving gaps in service delivery
- Clarifying and resolving controversies related to the provision of MRC-related disaster mental health interventions in the field

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

Overview and Clarification of the Term Debriefing

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

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

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

"*Operational debriefing* in first responder settings **is not a psychological intervention** but a collection of shared information (minus emotional processing), and may be helpful in allowing the construction of a more coherent, shared narrative of the incident among those who have worked together or have a shared support system."[5]

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

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

> *There is some Level 1 evidence (Level 1 evidence is considered the most reliable type of evidence in most cases) suggesting that early intervention in the form of a single one-on-one recital of events and expression of emotions evoked by a traumatic event (as advocated in some forms of psychological debriefing) does not consistently reduce risks of later developing PTSD or related adjustment difficulties.*
>
> *Some survivors (e.g., those with high arousal) may be put at heightened risk for adverse outcomes as a result of such early interventions.*[6]

Over the past five years mental health experts have continued to review the literature on the efficacy of psychological debriefing and have found similar conclusions. Ørner, Kent, Pfefferbaum, Raphael, and Watson (2006), reaffirmed the NIMH psychological debriefing findings and stated:

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[5]Ørner RJ, Kent AT, Pfefferbaum BJ, Raphael B, and Watson PJ. (2006). The Context of Providing Immediate Postevent Intervention. In: EC Ritchie, PJ Watson, & MJ Friedman (eds.), *Interventions Following Mass Violence and Disasters.* New York: The Guilford Press.

[6]National Institute of Mental Health (2002). Mental Health and Mass Violence: Evidence-Based Early Psychological Intervention for Victims/Survivors of Mass Violence. *A Workshop to Reach Consensus on Best Practices.* NIH Publication No. 02-5138, Washington, D.C.: U.S. Government Printing Office.

Overview and Clarification of the Term Debriefing - *continued*

> *There is currently no empirical evidence to support any intervention that utilizes components of trauma remembrance and emotional processing in the early phases following mass violence . . . .*
>
> *The most positive results from early interventions are usually for those that mobilize community support and address survivors' human affiliation needs (e.g., helping survivors establish contact with relatives) rather than interventions that focus on individual psychological reactions.*[7]

Summary and Recommendations

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

Because the findings (cited above and those included in the endnotes of this appendix) suggest that *psychological debriefing* does not prevent trauma-related mental health problems and puts some exposed persons at risk of adverse outcomes, it is the recommendation of this work group that *psychological debriefing or techniques that include trauma remembrance and emotional processing* should *NOT* be part of the routine MRC mental health response to disaster or other crisis situations.

The disaster mental health response begins long before a disaster occurs and should be an integral part of the overall community disaster plan. Ideally, plans will include an early focus on community education; discussions of realistic expectations following events; risk communication methods and content; triage and screening—both on the scene and in hospitals; post-event availability of psychoeducational information; community resilience activities; individual and group crisis counseling; and more definitive mental health treatment, when indicated, for those more severely affected by disaster.

Further, the responsibility for providing supportive interventions during disaster can and should extend beyond just the mental health professional alone. Educating and training all disaster responders in the concepts of Psychological First Aid or other supportive problem-solving and comfort care activities strengthens the overall disaster response and ensures that those individuals impacted by disaster and its aftermath have a greater opportunity to have their practical and psychosocial needs addressed early on and, as a result, potentially minimize long-term psychological consequences.

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

MRC Psychological Debriefing Position Statement Work Group:

Jack Herrmann, John Hickey, Edward M. Kantor, Patricia Santucci, James M. Shultz, and Alan Steinberg.

Additional Resources

Bisson, J., Jenkins, P., Alexander, J., & Bannister, C. (1997). Randomised controlled trial of psychological debriefing for victims of acute burn trauma. *Br J Psychiatry*, 171, 78-81.

Carlier, I.V.E., Lamberts, R.G., van Uchelen, A.J., & Gersons, B.P.R. (1998). Disaster related post-traumatic stress in Police Officers: A field study of the impact of debriefing. Stress Medicine, 14, 143-148.

Carr, V.J., Lewin, T.J., Webster, R.A., & Kenardy, JA. (1997). A synthesis of the findings from the quake impact study: a two-year investigation of the psychosocial sequelae of the 1989 Newcastle earthquake. *Int J Soc Psychiatry Psychiatr Epidemiol*, 32, 123-136.

Litz, B., Gray, M., Bryant, R., & Adler, A. (2005). Early Intervention for Trauma: Current Status and Future Directions. Retrieved April 3, 2006, from http://www.ncptsd.va.gov/facts/disasters/fs_earlyint_disaster.html.

MacFarlane, AC. (1998). The longitudinal course of posttraumatic morbidity: the range of outcomes and their predictors. *J Nerv Ment Disorders*, 176, 30-39.

Mitchell, J. (1983). When disaster strikes . . . the critical incident stress debriefing procedure. J *Emerg Med Serv*, 8, 36-39.

Raphael, B., Meldrum, L., & McFarlane, A. (1995). Does debriefing after psychological trauma work? *BMJ*, 310, 1479-1480.

Raphael, B., et al. (2000). Critical incident stress management and critical incident stress debriefings: evolutions, effects and outcomes. In B. Raphael and J. Wilson (Eds.), *Psychological Debriefing: Theory, Practice and Evidence* (pp71-90). London: Cambridge University Press.

Small, R., Lumley, J., Donohue, L., Potter, A., & Waldenström, U. (2000). Randomised controlled trial of midwife led debriefing to reduce maternal depression after operative childbirth. *BMJ*, 321, 1043-1047.

Wessely, S., Rose, S., & Bisson, J. (1998). *A systematic review of brief psychological interventions ("debriefing") for the treatment of immediate trauma related symptoms and the prevention of posttraumatic stress disorder* [CD-ROM]. Oxford, UK: Update Software, Inc.

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Appendix G:

- Resources

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Training Resources

Advanced Disaster Medical Response: A Manual for Providers
Briggs, S.M., & Brinsfield, K.H., (editors). Harvard Medical International, Inc., 2003.
http://www.amazon.com/gp/product/0972377204/002-8489036-2108026?v=glance&n=283155

Behavioral Health Awareness Training for Terrorism and Disasters
Shultz, J.M., Espinel, Z., Cohen, R.E., Shaw, J.A., Flynn, B.W., & Ursano, R.J.
Center for Disaster Epidemiology & Emergency Preparedness (DEEP Center), University of Miami School of Medicine, 2005 (first edition 2003).
http://deep.med.miami.edu

Community-based Psychological Support: A Training Manual
Published by the International Federation of Red Cross and Red Crescent Societies, 2003.
http://www.ifrc.org/what/health/psycholog/manual.asp

Disaster Behavioral Health: All Hazards Training
Shultz, J.M., Espinel, Z., Cohen, R.E., Smith, R.G., & Flynn, B.W.
Center for Disaster Epidemiology & Emergency Preparedness (DEEP Center), University of Miami School of Medicine, 2006.
http://deep.med.miami.edu

Disaster Behavioral Health OPERATIONS Training for Health Care Professionals
Shultz, J.M., Espinel, Z., Cohen ,R.E., Shaw, J.A., Flynn, B.W., Watson, P.J., Hick, J.L., & Schreiber, M.
Center for Disaster Epidemiology & Emergency Preparedness (DEEP Center), University of Miami School of Medicine, 2005.
http://deep.med.miami.edu

Disaster Mental Health: A Critical Response. A Training for Mental Health Professionals in Community Settings
Herrmann, J. University of Rochester, 2005.
http://www.centerfordisastermedicine.org/community_setting/

Disaster Mental Health: A Critical Response. A Training for Mental Health and Spiritual Care Professionals in Healthcare Settings
Herrmann, J. University of Rochester, 2006.
http://www.centerfordisastermedicine.org/healthcare_setting/

Disaster Mental Health Training: Guidelines, Considerations, and Recommendations
Young, B.H., Ruzek, J.I., Wong, M., Salzer, M.S., & Naturale, A.J. (2006). In E.C. Ritchie, P.J. Watson, & M.J. Friedman (eds.). Interventions Following Mass Violence and Disasters: Strategies for Mental Health Practice. New York: Guilford Publications.
http://www.istss.org/guilfordDMH.pdf

Training Resources - *continued*

Disaster Mental Health Response Handbook: An Educational Resource for Mental Health Professionals Involved in Disaster Management

Centre for Mental Health, NSW Health and NSW Institute of Psychiatry. New South Wales, Australia State Health Publication No: (CMH) 00145, 2000.
http://www.nswiop.nsw.edu.au/Resources/Disaster_Handbook.pdf

Disaster Mental Health Services: A Guidebook for Clinicians and Administrators

Young, B.H., Ford, J.D., Ruzek, J.I., Friedman, M.J., & Gusman, F.D. (1998). The National Center for Post-Traumatic Stress Disorder, Education & Clinical Laboratory, VA Palo Alto Health Care System, Menlo Park, California 94025; Executive Division, VA Medical & Regional Office Center, ,White River Junction, Vermont 05009.
http://www.ncptsd.va.gov/publications/disaster/

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

DeWolfe, D. J. (author). Nordboe, D. (editor). Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services DHHS Publication No. ADM 90-537, 2000.
http://www.mentalhealth.samhsa.gov/publications/allpubs/ADM90-537/Default.asp

Grief Counseling Resource Guide

Published by the New York State Office of Mental Health (OMH), 2004.
http://www.omh.state.ny.us/omhweb/grief/

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

Community Resilience Project of Northern Virginia. Commonwealth of Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, January 2004.
http://www.dmhmrsas.virginia.gov/CWD-HelpingToHeal.htm

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

U.S. Department of Health and Human Services. DHHS Pub. No. SMA 3959. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2004.
http://www.mentalhealth.samhsa.gov/media/ken/pdf/SMA-3959/MassViolenceAndTerrorism.pdf

National Disaster Mental Health Training Program

U.S. Department of Veterans Affairs, National Center for Post Traumatic Stress Disorder (NCPTSD)
http://www.ncptsd.org/about/training/ndmh_training.html

Psychological First Aid: A Field Operation Guide

Brymer, M., Jacobs, A., Layne, C., Pynoos, R., Ruzek, J., Steinberg, A., Vernberg, E., & Watson, P. (July, 2006). Psychological First Aid: Field Operations Guide, Second Edition.
http://www.ncptsd.va.gov/pfa/PFA.html or www.nctsn.org

Psychological Intervention for Victims of Mass Terrorism and Trauma

Buetler, L. National Center on the Psychology of Terrorism, Pacific Graduate School of Psychology.
http://www.terrorismpsychology.org

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

Shultz, J.M., Espinel, Z., Cohen, R.E., Smith, R.G., & Flynn, B.W. (2005).
Center for Disaster Epidemiology & Emergency Preparedness (DEEP Center), University of Miami School of Medicine.
http://deep.med.miami.edu

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

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

Issues and Populations of Special Consideration

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

U.S. Department of Justice, Civil Rights Division, Disability Rights Section
http://www.usdoj.gov/crt/ada/emergencyprep.htm

Assuring Cultural Competence in Disaster Response

The Florida Center for Public Health Preparedness
http://www.fcphp.usf.edu/courses_listings.htm

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

U.S. Department of Health and Human Services. Developing Cultural Competence in Disaster Mental. Health Programs: Guiding Principles and Recommendations. DHHS Pub. No. SMA 3828. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2003.
http://www.mentalhealth.samhsa.gov/media/ken/pdf/SMA03-3828/CulturalCompetence_FINALwithcovers.pdf

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

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services. DHHS Publication No. SMA 99-3378. Printed in 1999.
http://www.mentalhealth.org/publications/allpubs/sma99-3378/default.asp

Issues and Populations of Special Consideration - *continued*

Disaster Preparedness for People with Disabilities
American Red Cross national headquarters: Disaster Services, Health and Safety, Services, National Office of Volunteers, Office of General Counsel, and Risk, Management Division.
http://www.redcross.org/services/disaster/beprepared/disability.pdf

Helping Children after a Disaster
American Academy of Child & Adolescent Psychiatry, No. 36. Updated July 2004.
www.aacap.org/publications/factsfam/disaster.htm

Mental Health Care for Ethnic Minority Individuals and Communities in the Aftermath of Disasters and Mass Violence
Norris, F.H., & Alegria, M. CNS Spectrums. February 2005. Vol. 10, No. 2. p. 132-140.
http://www.cnsspectrums.com/pdf/art_637.pdf

Psychosocial Issues for Children and Families in Disasters: A Guide for the Primary Care Physician
U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services.
http://www.mentalhealth.samhsa.gov/publications/allpubs/SMA95-3022/default.asp

Psychosocial Issues for Older Adults in Disasters
U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services. DHHS Publication No. ESDRB SMA 99-3323
http://media.shs.net/ken/pdf/SMA99-3323/99-821.pdf

Disaster Relief Organizations, Agencies and Programs

American Association of Marriage and Family Therapy (AAMFT)
http://www.aamft.org

American Mental Health Counselors Association
http://www.amhca.org

American Nurses Association
http://www.nursingworld.org/news/disaster

American Psychiatric Association
http://www.psych.org

American Psychological Association (APA)
http://www.apa.org

American Red Cross Disaster Services (ARC)
http://www.redcross.org/services/disaster

Center for Mental Health Services (CMHS)
http://www.mentalhealth.samhsa.gov/cmhs

Department of Health and Human Services (DHHS)
http://www.dhhs.gov

Department of Homeland Security (DHS)
http://www.dhs.gov

Department of Veterans Affairs (VA)
http://www.va.gov/about_va/history

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

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

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

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

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

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

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

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

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

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