Handbook 2 – Psychological First Aid (PFA):
Level 1 Intervention following Mass Disaster
Psychological First Aid is a term to describe the strategies developed to support and protect people psychologically through the acute phase of disaster and the early aftermath. It involves principles of ensuring: survival, safety, shelter, protection, comforting and practical and psychological support to facilitate return to functioning, family and ongoing life. It may also be utilised in other acute / emergency situations to assist those who are very distressed.

**Aims**

1. **To provide:**
   - A brief overview of the evolution of PFA, its current status and evidence supporting it
   - An overview of expected reactions following disaster and the concept of resilience as it applies to a PFA approach

2. **To describe:**
   - A clear and simple description of Psychological First Aid including:
     - The actions it involves and their rationale
     - What it is, what it is not, and who can provide it
     - When, and for whom it is indicated
     - The strengths and limitations of PFA
     - Outcomes sought
     - The Do’s and Don’ts in offering Psychological First Aid responsibly

3. **To describe:**
• Core Principles
• Core Skills and competencies required

4. To identify special considerations relevant to PFA, and their implications

• Guidance on offering Psychological First Aid to special groups such as children and adolescents
• Guidance on recommended, relevant, evidence-informed or tested resources that will further support the delivery of PFA and related needs

Psychological First Aid has been described in many different ways. The World Health Organisation in its recently released Guide for Field Workers describes it as: “a humane, supportive response to a fellow human being who is suffering and who may need support”. (p.3).

1. Psychological First Aid: Evolution; Evidence and Disaster Context

The concept of Psychological First Aid (PFA) as applied in the acute post disaster phase is not a recent one (Drayer et al., 1954; Raphael 1977; 1986). In 1986 Raphael wrote a comprehensive overview of the essential components of PFA, the nature of psychosocial support and adaptive coping in the emergency and immediate aftermath following disaster. This process involved the identification and management of those at risk; and triage and management for specific syndromes should they arise. Time has seen those concepts and the study of disaster psychiatry evolve to the point where the key elements of PFA; human empathy and caring, have been reinforced as a vital aspect of the response in the initial aftermath of disaster, alongside the critical issues of assuring safety, practical support such as shelter, protection, food and water, as well as linkages to family and support. The evolution of PFA concepts and their operationalisation, has been an international process resulting in a number of excellent recommendations and guidelines which emphasise a simple, practical approach that does no harm. PFA is currently recommended by the National Institute for Mental Health (http://www.nimh.nih.gov/, 2002), National Centers for PTSD (http://www ptsd.va.gov/, 2006), the National Child Traumatic Stress Network,
(http://www.nctsn.org), the World Health Organisation (http://www.who.int, 2011) and other lead agencies such as the International Red Cross (http://www.icrc.org/) who are providing training and disseminating resources with the key PFA principles and requisite skills.

The Australian Red Cross has also developed a valuable resource for Psychological First Aid. It emphasises useful themes that are also reflected in this volume. This resource describes Psychological First Aid as an approach to helping people affected by an emergency, disaster or other distressing event. It is informed by common sense principles to promote recovery and to help people feel safe and calm, to connect with others. It also aims to promote hope and optimism. The full Red Cross resource is available at: http://www.psychology.org.au/Assets/Files/Red-Cross-Psychological-First-Aid-Book.pdf.

Psychological First Aid starts with the recognition of distress but also the expectation of resilience, and does not assume that psychological disorder is inevitable. Thus people may be intensely distressed but are not (in the acute post-disaster phase) viewed as patients or clients. Numerous studies have highlighted the problems associated with early intervention after disaster, and what might be effective. For example, Van Emmerik et al (2002), in a meta-analysis of psychological debriefing, concluded that there was no evidence that Critical Incident Stress Debriefing (CISD), and indeed other similar non-CISD interventions assessed at that time, improved recovery. This was further supported by Kenardy & Carr’s (2000) findings after the Newcastle earthquake, and also supported by Gist and Devilly (2002). PFA is unlike interventions such as CISD, which has been found to be ineffective, possibly harmful for some, and thus discouraged (Raphael & Wilson 2000; Bisson 2007; Bisson & Lewis 2009; NIMH 2002; Rose, Bisson & Wessley 2003). Unlike CISD, PFA does not involve probing those affected about their experience in the disaster and their reactions, and is designed to promote a calm, caring and supportive environment to assist psychological recovery. *Debriefing* as a concept has been popular, and is widely used in everyday language (e.g. when things go wrong we ‘debrief’). Such informal human reactions are common and not the focus of this discussion. Formal, structural Psychological or Critical Incident Stress Debriefing is not supported by evidence despite multiple studies. Some studies suggest that it may have negative effects for some people. Terms such as *operational debriefing*, which is a form of practical review of the disaster operation, should be clearly distinguished from *psychological debriefing* when discussing preparation, planning and response to a disaster. “Debriefing” may occur as spontaneous sharing of the experience, but this is part of the spectrum of human adaptation and not a formal or structural technique.
Some of these approaches merge into assessment and early intervention for trauma syndromes. For instance Bisson et al (2010) attempted to develop guidelines for post disaster psychosocial care through a Delphi process to achieve consensus. They found that there was agreement about the need to provide general support, access to social, physical and psychological support, and more detailed interventions only after there had been comprehensive assessment to indicate the need for these. PFA aims to protect and sustain life, safety and survival, to comfort and reassure; to enhance positive coping; and promote connectedness and hope. It is NOT a clinical or diagnostic process and is primarily focused upon practical needs and is supportive and noninterventionist. PFA is not sufficient as a secondary prevention strategy, but by ‘reducing arousal, anguish, dysphoria, and disconnection, and enhancing coping and control, risk can be lowered and recovery is more likely’ (Litz, 2008, p. 504). While the current consensus is positive for a PFA approach, and there is extensive discussion of such early intervention strategies (e.g. Ritchie et al, 2006), it should be remembered that although PFA components are intended to be generic and supportive, they require ongoing research and evaluation. It is considered that the generally supportive nature and non intrusive interventions suggest that they are unlikely to do harm. Experts agree that PFA practices are evidence-consistent, if not evidence-based, in that they are drawn from research on protective and risk factors associated with post traumatic recovery’ (Watson 2007, p. 133).

**Operationalising PFA.** The studies reviewed contain a range of descriptions and models of PFA, with the majority being used for the emergency disaster context, but with some more clinically focused. Following the early writings discussed above, particularly following the seeming increase in international terrorism and other large scale mass disasters, models of PFA have been operationalised and disseminated by leading international organisations such as the National Institute of Mental health (NIMH, 2002, http://www.nimh.nih.gov), National Child Traumatic Stress Network (NCTSN), the National Centre for PTSD (NCPTSD) (http://www.ptsd.va.gov/), and the International Red Cross (http://www.icrc.org/). The NCTSN has a number of excellent resources which will be highlighted throughout this chapter and has been conducting research and evaluation of these.

In 2006 The NCTSN and The National Centre for PTSD, released the Psychological First Aid: Field Operations Guide (http://www.ptsd.va.gov/professional/manuals/psych-first-aid.asp), which has
been widely used to train and assist disaster responders and survivors of mass emergencies. A number of useful handouts and resources is provided and a selection of these has been included in appropriate sections throughout this volume and adapted for an Australian context.

Another model is that proposed by Rooze et al (2008) “Basic Psychosocial Life Support”. Rooze’s group proposes this model for use in the acute phase of response during and after disasters. They developed this through a consensus process, which involved issues such as Psychological First Aid, community participation and risk communications. The acute psychosocial first aid, civil participation and resilience, and risk communication components focused on the fact that most responders will be members of the community or a specific organisation, and that their understanding and engagement in emergency response is critical. They also highlight critical aspects of triage for those who are severely and acutely distressed. Many of these themes are covered in diverse ways in the material in this resource. It is important to note that there is also emphasis on the importance of providing psychosocial care through primary care and in association with understanding physical health needs for service provision.

**Australians and Disaster**

Australians are not strangers to disaster. For decades they have experienced, responded and travelled the journey to recovery from a variety of natural (eg. bushfires and floods), accidental (Granville train disaster) and intended (the Bali bombings) disasters. In many cases all levels of government have been involved and with recent offshore terrorist attacks and international health pandemics, the Australian Federal government has worked closely and collaboratively with other governments and their agencies. Australian organisations such as Emergency Management Australia (EMA) and the Australian Psychological Society (APS), have drawn from these experiences and have developed some useful resources following recent incidents such as the 2009 Victorian bushfires. Other national organisations such as the Australian Centre for Posttraumatic Mental Health (ACPMH) have developed and released treatment guidelines for those suffering Acute Stress Disorder (ASD) or Post Traumatic Stress Disorder (PTSD) (http://www.acpmh.unimelb.edu.au/). They also developed resources following the 2009 Victorian bushfires for three levels of training, the Level 1 program being for Psychological First Aid. Specific guidelines for general mental health support; Level 2 training, such as Skills for Psychological Recovery; and for Level 3, Specialist Training,
targeted post disaster guidelines to address significant psychiatric morbidity; have also been developed.

For many years PTSD has been the ‘signature diagnosis’ in the disaster response field. However, in parallel with the extensive trauma literature there has been a growing recognition and focus on the vital importance of *bereavement* as a distinct entity and also bereavement syndromes, particularly traumatic grief (Raphael 1983; Raphael 1997; Raphael & Minkov 1999; Shear et al 2005; Prigerson et al., 2006). This has overlapped with concepts of Complicated or Prolonged Grief Disorders (Prigerson et al 2009, Raphael et al 2011). This has added depth and greater understanding to the recovery field. However integrating bereavement into a PFA approach (ie. how we best support the bereaved in the acute and immediate period following disaster) has yet to be well defined and operationalised in many current models of PFA. The PFA strategies for acute disaster can assist, but uncertainty, separation and the realities of loss of a loved one may require additional acute support (see Chapter 13).

**A three level approach to psychological support following mass disaster:**

As noted above there is consensus in Australian disaster mental health management that such a multi-level or stepped approach is optimal. It is important to state that PFA is a strategy *woven into an organised disaster response process*, and forms part of an ‘All Hazards’ approach for Prevention, Preparation, Response and Recovery (PPRR) processes.

They are:

<table>
<thead>
<tr>
<th>LEVEL 1</th>
<th>Psychological First Aid (PFA) in the immediate aftermath</th>
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<tbody>
<tr>
<td>LEVEL 2</td>
<td>Skills for Psychological Recovery (SPR)</td>
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<tr>
<td></td>
<td>(weeks and months following) as one of a range of programs for generic needs</td>
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<tr>
<td>LEVEL 3</td>
<td>Specialised mental health interventions</td>
</tr>
<tr>
<td></td>
<td>(as appropriate to need, or from about 4 weeks or longer onward) and targeted for those with established post-disaster psychiatric morbidity.</td>
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</table>

This chapter will deal with Level 1 and link this to a brief overview of Level 2 interventions. A full review and discussion of Level 2 and specialised Level 3 interventions is included in specific chapters.
of this Handbook. Thus as a Level 1 intervention, PFA is not counselling or debriefing and while encompassing risk identification and triage, is not intended as a specialised clinical response. Its value is in its fundamental message that response following disaster is a human, caring and compassionate process linked directly to the priorities of ensuring survival, safety and the necessities of life. It can be delivered by people who are trained appropriately and as part of a larger response effort. It should also be noted that some models of PFA move toward a more clinical framework, which is an important part of this field. However the Australian model described in this handbook is considered appropriate as the current response. This approach is supported by a similar focus in the WHO Psychological First Aid: Guide for Field Workers (WHO, 2011).

Recognising and supporting personal and community resilience

It is generally accepted that most people will be resilient following a disaster (Raphael 1986, Bonanno 2004; 2006), and will not develop significant pathology. There is ongoing debate as to the definition of resilience, however it is generally agreed that resilience is a universal human capacity that allows a person, group or community to prevent, minimise, overcome and even be strengthened by experiences of adversity. Resilience is about adapting to or ‘bouncing forward’ (Walsh, 2002) after a traumatic experience, although how/why some people are able to do this more so than others is an elusive answer. People may be developmentally resilient (eg. to a difficult childhood). Communities and societies can also be resilient. Community or societal resilience has been the focus of much interest and research about disasters suggesting that it is an important factor in how communities respond (Norris et al., 2008) and how social institutions may be helpful in recovery. Kessler and colleagues (2006) found that 88.5% of the affected population following Hurricane Katrina in the United States reported that their experiences helped them develop a deeper sense of meaning or purpose in life. The vast majority (89.3%) reported that they would be better able to cope with future life stressors. This relates to concepts such as those of “Post Traumatic Growth”.

Many researchers and practitioners working in this field would agree that resilience is spontaneous and it is important to recognise the natural resilience of people and communities. For those involved in an All Hazard Prevention, Preparedness, Response and Recovery (PPRR) approach, and particularly those delivering PFA, it is essential to recognise and support people’s struggle, and their resilience. It is also important to recognise that people can be suffering and still resilient and this can occur in
times of extreme distress (Wessely 2005). For a full discussion of the nature of resilience as it relates to mass disaster see the relevant chapter in this Handbook.

**Normal adaptations and coping responses**

As discussed, most people will be resilient and will recover and do not go on to develop significant mental health issues. Nevertheless while survivors may be shocked and distressed at least initially, most go on to exhibit a range of normal coping responses which include 1) seeking help from others or offering help to others; 2) talking about their experiences and trying to make sense of what happened; 3) trying to stay safe until the danger has passed, and 4) seeking information about the welfare of their loved ones. They may “fight” to survive, “take flight”, or “freeze”, but go on to adapt.

Other common general reactions over time may include:

<table>
<thead>
<tr>
<th>Emotional:</th>
<th>Arousal, fear, helplessness, grief, anger, being on edge, numb, disbelief</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive:</td>
<td>difficulty concentrating, preoccupation, worry, images, memories, problems with decision making</td>
</tr>
<tr>
<td>Social:</td>
<td>social withdrawal, conflict, relationship problems</td>
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</table>

A number of useful information handouts (for responders and survivors) on types of reactions are included in the appendices section of this chapter and range in their clinical emphasis (eg. note Appendix A ‘Normal Response and Reactions’, DRGGG 2010, vs Appendix B ‘When Terrible Things Happen’, NCTSN & NCPTSD, 2006).

**Personal Support**

This is the supportive process that may be needed as the acute distress settles and aims to assist people in the aftermath, for instance with information, practical assistance and linking to necessary services and resources. This process, like Psychological First Aid, may be utilised in contact with people who are severely distressed, or who may have continuing significant difficulties. It may indicate the need for further assessment and possibly management. General Principles are outlined later in this chapter.
2. What is Psychological First Aid?

As discussed, Psychological First Aid is a *commonsense approach* that draws on *human compassion* and *kindness*. It *is about practical strategies for survival* and provides a calm, caring and supportive environment to promote psychological recovery (Raphael 1977; 1986; 2000). PFA is based on an understanding that disaster survivors and others affected by such events will *experience a broad range of early reactions that may be physical, psychological, behavioural, and spiritual*. Some of these reactions will cause enough distress to interfere with adaptive coping and others will not (Brymer et al., 2006). Recovery may be helped by support from compassionate and caring disaster responders. Most importantly, PFA does not assume that survivors have or will develop significant mental health problems or clinical syndromes. Thus it is designed to reduce the initial distress caused by traumatic events and to foster short- and long-term adaptive functioning and coping.

As discussed, PFA is currently the best evidence-informed approach and is recommended by the *US Consensus Conference on Early Intervention and Mass Violence* which states that ‘the primary helping response at this time for all workers should be psychological first aid’ (NIMH, 2002). ([http://www.nimh.nih.gov/health/publications/massviolence.pdf](http://www.nimh.nih.gov/health/publications/massviolence.pdf)).

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

(NIMH 2002; NCTSN 2006)

**Psychological First Aid: Integrating the Response with the Disaster Management Systems**

Psychological First Aid may be part of a spontaneous response where people are responding when their communities are affected by disaster or other incidents, and they are supporting more
distressed members of the community. They may also be affected themselves, i.e. they are the informal ‘first responders’. This is not a formal response, but is a valuable support process in such circumstances.

It is very important that Psychological First Aid is provided as an agreed component of the Disaster Management system. Thus those trained and identified would be mobilised formally, would have identification and ‘badging’ as appropriate, and would operate under the management structure as part of a team. They would be deployed to assist, usually briefed with specific directions as to where and how they will operate in the particular context, and the processes by which they will report and act. This is important for people responding in the acute phase and subsequently, as they need to understand where they fit into the overall structure of response, their roles and limitations, and the roles of other responders. In this context physical survival of those affected will take priority. Furthermore, PFA providers and all responders should understand that at certain stages other roles / interventions / operations may have priority. They should also be aware of their responsibility not to become a casualty themselves, to behave in ways that will protect their own safety as well as that of others. They will need to be aware of their responsibilities – first not to harm, their aims of support, optimising assistance to patterns of need, so as to achieve greatest good for greatest numbers; and their accountabilities, with potential documentation requirements and step-down review.

Who is Psychological First Aid For?

PFA is appropriate for anyone who is acutely or severely distressed or affected by an emergency, a stressful incident or disaster event. Its strategies are intended for use with adults, children, adolescents, parents/caretakers, and families, exposed to disaster or terrorism or indeed other adversities. PFA can also be provided to first responders and other disaster relief workers.

Who Delivers Psychological First Aid?

Psychological First Aid is delivered by trained disaster response workers who provide early assistance to affected children, families, and adults as part of an organised disaster response effort. These providers may come from a variety of response systems or organisations including first responder teams, incident command systems, primary and emergency health care, disaster relief organisations, and faith-based organisations. They do not have to be from specialised mental
health agencies, however specialised mental health workers are important providers of PFA in emergency settings; particularly where there are very significant stressors and high levels of associated distress.

Dealing with acute distress may merge into more general support of those affected.

Whether as part of a planned response or not, ‘disaster responders’ may also include established and trusted people or services such as community members, health professionals such as nurses, community pharmacists or general practitioners. These people may often act in informal ways by giving advice on where to go and who is appropriate to talk to. For example, after the 2009 bushfires, it was noted that a number of families chose to talk to their local pharmacist, seeking advice from them. Given that strong social capital is reflected in these trusted sources, it is crucial that PFA responders identify and utilise such local networks to encourage and promote further community resilience.

**When and where should Psychological First Aid be used?**

PFA is a supportive intervention for use in the immediate aftermath of disasters and terrorism and is designed for delivery in diverse settings. PFA is most appropriate for those who have been very recently affected – from immediately after, or a few days or possibly weeks, after a crisis has occurred. Disaster response workers may be called upon to deliver PFA in a wide range of settings depending upon the nature of the disaster. These include: at the disaster scene, community/neighbourhood centres, schools, general population shelters, field hospitals and medical triage areas, acute care facilities (for example, Emergency Departments), staging areas or respite centres for first responders or other relief workers, emergency operations centres, crisis hotlines or phone banks, food provision locations, disaster assistance service centres, family reception and assistance centres, homes, and other community settings. It should encompass safety of place as far as possible, both for those affected and for providers.

As each crisis event is different, the social rules and culture of the individual or groups affected will also influence how help is offered and what a responder may say and do. For example, touching someone’s hand may be comforting in one culture but offensive in another; or in some cultures it is more appropriate for women to speak with other women. Touch is a useful technique for others in
times of distress, for example during the recovery period, if people become acutely distressed by reminders of the initial exposure, or new traumatic situations arise. For further information and examples of cultural adaptations of PFA see Chapter 5 of PFA: A Guide for Field Workers (WHO, 2011).

What Psychological First Aid is NOT?
(This section reflects similar principles to Psychological First Aid: A Guide for Field Workers, WHO, 2011, p.3)

• It is not a support process that’s delivered only by mental health workers or other professionals
• It is not stress debriefing or counselling.
• It is not an investigation into exactly what has happened, or asking people to describe their experiences in detail, unless they spontaneously wish to do so.
• It is not compulsory and in some cases may not be necessary.
• It is not Mental Health First Aid. PFA and MHFA sometimes confused however the two are quite distinct. MHFA is the help given to someone experiencing a mental health problem before professional help is obtained.

The aims of Mental Health First Aid are: To teach people about mental health problems and disorders, how to recognise them, and how to assist people affected.

• to preserve life where a person may be a danger to themselves or others
• to provide help to prevent the mental health problems developing into a more serious state
• to promote the recovery of good mental health
• to provide comfort to a person experiencing a mental health problem
• to raise awareness of mental health issues in the community
• to reduce stigma and discrimination

(Sources: NCTSN 2000; Australian Psychological Society, PFA Consensus Development Discussion 2009; Jorm, Orygen Research Centre, University of Melbourne 2009)
3. Psychological First Aid: Core Principles and Skills

As noted previously there has been a range of models for PFA, from those most clearly linked to emergency situations, to those more clinically focussed. Much of this orientation reflects the degree to which the psychological strategies are emphasised in more clinical terms. It is critical for those involved to recognise that they operate as a member of a team and with many other responders as part of the Disaster Management System. These models apply to principles and skills when they are formally deployed as part of disaster response. In different settings they are part of the repertoire of human skills to assist others. The core principles and skills reflect this spectrum. The range of models is described below. As identified in this description there are common core principles throughout.

An early model built on work previously (Raphael, 1986) and is reflected in the description below.

<table>
<thead>
<tr>
<th>PFA aims to provide psychosocial support reflecting aims similar to those of Physical First Aid – to assist people in the emergency / disaster situation to survive, to minimise psychological injury and to facilitate recovery. It involves:</th>
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<tbody>
<tr>
<td>• Protecting from further harm, ensuring survival, safety and security</td>
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<tr>
<td>• Providing basic human responses of calming and comforting those affected</td>
</tr>
<tr>
<td>• Providing or assisting the person with necessities such as shelter, water, food, warmth</td>
</tr>
<tr>
<td>• Providing information and assessing acute current needs</td>
</tr>
<tr>
<td>• Linking / connecting to family and other supports</td>
</tr>
<tr>
<td>• Providing information and ongoing options for communication</td>
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</table>

(from NSW Disaster Mental Health Response Handbook, 2000)
These principles were further supported by the Consensus Conference in the USA for Early Intervention after Mass Violence (NIMH, 2000), reflected below:

Psychological First Aid is the second of 9 listed ‘Key Components of Early Intervention’ as follows: Basic Needs; Psychological First Aid; Needs Assessment; Rescue and Recovery Environment Observation; Outreach and Information Dissemination; Technical Assistance, Consultation and Training; Fostering Resilience and Recovery; Triage, and Treatment.

The Consensus Conference’s key principles of Psychological First Aid are:

• Protect survivors from further harm.
• Reduce physiological arousal.
• Mobilise support for those who are most distressed.
• Keep families together and facilitate reunions with loved ones.
• Provide information and foster communication and education.
• Use effective risk communication techniques.


These models have evolved further to encompass the necessity for triage for acute distress, as for acute physical health need. This is described in the diagram below and offers a “structural” representation for what is basically a human and flexible process determined by the nature of the emergency incident / disaster, the individual’s or group’s experience of it, and the basic needs of those affected for physical and psychological services. Here, as above, physical survival is the first priority, with a focus on those with greatest need, optimising numbers that can be assisted with the capacity to service.

A number of shorter forms, representing the core principles more succinctly have also been developed and are represented in the SAFE model following:
A review of many of the specific papers relevant to this resulted in the following very influential core principles. Review of research identified 5 overarching principles that should inform mental health response in the emergency and early post-disaster period. They are also more broadly relevant. These resulted from Hobfoll’s (2007) review of principles relevant to immediate and midterm response, and described in the NCTSN and NCPTSD (2006), models of Psychological First Aid.

<table>
<thead>
<tr>
<th>Keep S.A.F.E</th>
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<tbody>
<tr>
<td>SAFETY</td>
</tr>
<tr>
<td>• Establish immediate safety</td>
</tr>
<tr>
<td>• Offer practical help and emotional support</td>
</tr>
<tr>
<td>AROUSAL</td>
</tr>
<tr>
<td>• Reduce intense arousal</td>
</tr>
<tr>
<td>• If overwhelmed, calm and orientate the person</td>
</tr>
<tr>
<td>• Demonstrate slow breathing</td>
</tr>
<tr>
<td>FEAR</td>
</tr>
<tr>
<td>• Provide information about risks</td>
</tr>
<tr>
<td>• Actions (theirs / others) – to keep safe</td>
</tr>
<tr>
<td>• Reassure – stress reactions are normal</td>
</tr>
<tr>
<td>EMPOWER AND EXIT</td>
</tr>
<tr>
<td>• Let people talk if they want to</td>
</tr>
<tr>
<td>• Help people act for themselves, then move on</td>
</tr>
</tbody>
</table>

(Paul and Raphael, 2008a & 2008b)

PFA Principles NCTSN & NCPTSD (2006) & Hobfoll’s 5 Key Principles

- Promote Safety & Survival
- Promote Calming, Comforting & Reassurance
- Promote Self and Community Efficacy
- Promote Connectedness
- Promote Hope

(Psychological First Aid, Field Operations Guide 2nd Edition
www.nctsn.org and www.ncptsd.va.gov)
A further evidence-informed model was developed based on Watson’s overview of this field. The NCTSN model defines **8 core skills and their goals**. The program described is informed by the available evidence and is built on a more clinical approach. It is summarised in the components below.

**PFA Principles based on best available evidence of 8 core skills & goals.**

1. **Contact and Engagement**  
   Goal: To respond to contacts initiated by people, or 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. **Stabilisation (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 to help them feel safer and calmer

6. **Connection with Social Supports**  
   Goal: To help establish brief or ongoing contacts with primary support personal or other sources of support, including family members, friends, and community help resources

7. **Information on Coping (for Practical Assistance)**  
   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.

This is a valuable and detailed framework perhaps most useful when assuming a clinical process. A number of excellent resources for implementing key PFA skills such as calming and grounding, breathing techniques and so forth are included in Appendix E.

The World Health Organisation has recently released an important and up-to-date resource relevant to many settings, especially in low-income settings. This is the Psychological First Aid: Guide for Field Workers (WHO, 2011). It describes a number of key principles, many similar to those identified in the models above. It describes the following themes in PFA:

- Providing unintrusive practical care and support
- Assessing people’s needs and problems
- Helping people with basic necessities (e.g. food, water, shelter)
- Listening, without pressuring people to talk
- Providing comfort to people and assisting them to feel calm
- Helping people get information and get contact with services, social and family supports
- Protecting those affected from further injury, physical or psychological.

(Adapted from Psychological First Aid: Guide for Field Workers, p.3, WHO, 2011)

The resource also emphasises other elements of helping responsibly, including cultural sensitivity, good communication, as encompassed by the following:

**Respect people’s:**

- **Safety:** protecting people from further physical or psychological harm, including as a result of one’s own action
- **Dignity:** take into account cultural and social considerations for those affected, including about language, dress, behaviour and customs
- **Rights:** make sure access to help is available without discrimination, help people claim their rights to available support, and act only in their best interests

(Adapted from Psychological First Aid: Guide for Field Workers, p.8, WHO, 2011)
Aspects of good communication in delivering PFA include:

- Being calm, patient, quiet but attentive, and being aware of body language
- Acknowledging the person’s losses and their strengths
- Being honest in providing factual information and maintaining confidentiality if appropriate
- Not pressuring or rushing a person, or telling them how they should feel
- Not interrupting or telling other people’s or your own troubles
- Not giving false promises or reassurances
- Remaining non-judgemental

In preparation for delivering PFA in a crisis site, learning about the following is important:

- What is the crisis, when and where did it happen, who and how many are affected?
- What services and supports are available, e.g. for basic needs, physical resuscitation and transfer to urgent medical care; how are these accessed, and who else is helping / responding and in what ways
- Safety and security – is the crisis over, what dangers may remain in the affected area, are there any no-go zones?

Importantly this report reconnects **3 BASIC ACTION PRINCIPLES:**

**LOOK:** check for safety, find those with priority needs, or serious distress.

- If the site is still dangerous (e.g. conflict, floods, fire, unstable structures etc) and your safety cannot be guaranteed, do not enter the site. Try to get help and if possible communicate from a safe distance with those distressed.

- If people are seriously injured, need medical help or need rescuing, refer to medical or rescue personnel. Assess who has basic immediate needs e.g. food, water, clothing, and who may need help accessing these or other services, or may be at risk of discrimination.

- Assess who the most distressed people are, e.g. in shock or dazed, “frozen”, disoriented or not responding to other people
• Look for those who may need special attention:
  
  o Children / adolescents may be separated from their caregivers and need help with basic requirements as well as possibly protection from harm or exploitation
  
  o People with physical or mental conditions or disabilities may need help accessing services, medical care or accessing medication. This may include the frail or elderly, pregnant women, those with visual or hearing impairments.
  
  o Those at risk of discrimination or violence, such as women or people of certain ethnic groups, may need help getting to safety and support in the crisis setting

**LISTEN**: to those who need support, to their concerns, help them to feel calm. Listen with Eyes (full attention), Ears (truly hearing the worries of those affected) and Heart (with genuineness and respect).

• Approach those who may need support respectfully and in an appropriate manner, place and time. Introduce yourself and your organisation and try to keep their physical safety, privacy and dignity protected.
• Ask about needs and concerns, find out what is most urgent, i.e. shelter, clothing or information, and prioritise these needs
• Listen without pressure and in the case of the person being severely distressed, try to ensure they are not alone.
• Help those anxious, upset or physically stressed, to feel calm. This can include techniques such as:
  
  o Keep voice calm and soft
  
  o Maintain some eye contact while speaking, unless this is culturally inappropriate
  
  o Encourage the person to focus on their current surroundings, and focusing on their slow and calm breathing.

**LINK**: people to basic needs and services, to information, to their loved ones, to further support.
• Try to help the distressed person with basic needs they request such as food or shelter, as well as specific needs such as health care, items for feeding children. Try to link them with available services and follow up if necessary.

• Help people to cope. This can include identifying people who can support them such as friends or family; helping the person with practical suggestions to meet their needs such as registering for aid or assistance; affirming a person’s ability to cope and asking them to consider how they have used their strengths to cope with previous difficulties.

• Encourage positive coping strategies such as getting sufficient rest, eat and drink water regularly, talk to family and friends, do activities that they enjoy, exercise, etc.

• Discourage negative coping strategies such as alcohol or substance use or abuse, excessive sleeping or working, being withdrawn, neglecting hygiene etc.

• Link people with sources of accurate, regularly updated and trusted information; including about the following:
  o Ongoing safety issues and situation updates
  o People’s rights
  o Available services and how to access them, including contact details
  o The condition of missing or injured people
  o Plans for response and recovery

In this situation it is important to convey clear and accurate information, only relate what is known to be true, and explain the reliability of the message.

• Link people with sources of social support, friends and family and community or spiritual groups, or groups of affected people for mutual support

**PFA for children in crisis** has 3 SIMILAR CORE PRINCIPLES (Schreiber & Gurwitch, 2006):

• LISTEN
• PROTECT
• CONNECT

These will be dealt with in more detail in subsequent chapters.
Respectful Engagement

Compassionate understanding, validation of the concerns of those affected, and positive expectations represent the principles that should inform response in all models. These principles are important for individual resilience but are also likely to contribute to broad community level resilience (Norris et al., 2008). For example, ongoing efforts to rebuild community connections such as through the return to functioning of schools, transport, banking and shops, all help to re-establish everyday routines and create an environment of safety and hope for individuals, their family and the entire community.

Identification of those at greatest risk or with greatest need and triage to appropriate care, follow-up and monitoring

In the acute phase, once physical safety and urgent medical care are addressed, there may be as well much anxiety, arousal and possibly fear, and confusion. It is essential that those in most immediate need and severe levels of distress are identified quickly and triaged to appropriate care (eg. those decompensating are transitioned to further specialised mental health assessment), and that those at lesser risk are identified, supported and followed up as appropriate.

While it is important that specialised mental health expertise and specialised assessment strategies are available at this time, the acute phase is one where many are highly distressed and flexibility is needed. While most are resilient, there may be a small number of people in immediate acute need. Those whose needs must be most urgently addressed include people with life-threatening injuries who need emergency medical care; with emotional distress that is so severe that they cannot function in the basic aspects of their daily lives and need immediate referral; or people who may be actively suicidal or at risk of hurting others. In these situations, it is appropriate to seek assistance and refer the person to other services or people who can provide more specialised support.

When to refer? The ABC of Psychological Triage

A needs assessment should consider a number of things. Firstly, individuals who exhibit extreme acute reactions may put themselves or others at risk in the situation. They may appear dazed and disoriented, unable to comprehend their surroundings, or they may be withdrawn, detached,
agitated, overreactive, or be experiencing panic symptoms. If these reactions do not rapidly abate then more focused support beyond PFA is needed. When this is possible, people so affected should be rapidly referred for medical/mental health assessment (for example to exclude the possibility of head injury or neurological damage) and, if appropriate, specialised intervention.

Others may have pre-event risk factors or within disaster stressors that have been identified in studies as increasing the risk of adverse mental health outcomes and thus may place them at risk. It is often the case that the way a person talks about possible solutions provides an opportunity for a PFA provider to gauge the survivors’ confidence in their ability to address their concerns (Benight et al., 1999; Young, 2006). Information can be gathered with questions like; ‘what are the key issues you are dealing with, what can we do to help you with those’?

It is normal that anxieties will be high and there may be intense fear, particularly in the case of a massive natural disaster, terrorism or a CBRN attack with, for example, a toxic gas exposure where the threat is unseen and unknown. This may lead to extreme anxiety resulting in an inability to function. People may experience dissociative reactions including: detachment, derealisation, depersonalisation or a dreamlike interpretation of their surroundings. They may experience prolonged, intense fear or other uncontrollable, distressing emotions, or be unable to sleep or eat. Some may have cognitive difficulties and be confused or have trouble concentrating or making decisions. Such confusion may indicate organic factors, head injury, toxic effects, substance issues or dissociative reactions. Thus it is important to identify those in immediate need and ensure their care in addition to ensuring that those at higher risk are supported and followed up.

The ABC of triage (assessing and responding) includes:

- **Arousal** (if excessive): calm, relax, breathing or emergency care & sedation
- **Behaviours** (if high-risk & disruptive): monitor, calm, contain for safety, mental health assessment
- **Cognitions** (if disrupted, confused): advise, reality / protection; monitor for organic impairment

If Arousal is so intense it cannot be managed, Behaviour so affected that it places the person or others at risk, if Cognitive impairments impact severely on function, for instance confusion, inability to focus; the person should be triaged to further assessment and management.

Source: Dr Cath Hickie & the Disaster Response, Resilience & Research Group (DRRRG), School of Medicine, UWS, 2009
## PFA, Triage & Management

<table>
<thead>
<tr>
<th>PFA</th>
<th>Triage</th>
<th>Mental Health Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Survival, safety, security, shelter</td>
<td>ABC:</td>
<td>Severe or ongoing difficulties</td>
</tr>
<tr>
<td>- Comforting</td>
<td></td>
<td>Mental Health assessment / intervention</td>
</tr>
<tr>
<td>- Information / communication</td>
<td>- A – Arousal excess</td>
<td>Mental health assessment/intervention</td>
</tr>
<tr>
<td>- Assessing needs, provide basic needs</td>
<td>- B – Behaviour risk</td>
<td>Medical/surgical assessment/intervention</td>
</tr>
<tr>
<td>- Family – connect</td>
<td>- C – Cognitive problems</td>
<td>Follow up, screen, assess, manage, treat</td>
</tr>
<tr>
<td>- Goal orientation and actions by those affected</td>
<td>- Acute decompensation and psychiatric dysfunction</td>
<td></td>
</tr>
<tr>
<td>- Linking to support networks</td>
<td>- Injury, physical health impacts, first aid</td>
<td></td>
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<td></td>
<td>- Risk factors for adaptation</td>
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(Adapted from Raphael, 1986, p.258)

### How to approach Psychological First Aid responsibly?

Professional guidelines for delivering PFA have been discussed by the NCTSN and the World Health Organisation (WHO, 2011). Overall they emphasise that delivery of PFA is most effective if the responder is calm, focused and prepared and that, most importantly, they do not harm, and stay safe, do not become casualties themselves.

Three basic Do No Harm Principles nominated by the WHO (2011) are listed below;

- Respect the person
- Protect the person from harm
- Act only in the best interest of any persons you encounter
The Dos and Don’ts of Psychological First Aid

Many resources and much advice exist on what to do and not to do in emergency situations. One excellent resource for responders is the NCTSN handout on supporting individuals in disaster (Ursano et al., 2005).

It includes such things as:

**DO:**

- Do help people meet basic needs for food & shelter, and obtain emergency medical attention. Provide repeated, simple and accurate information on how to obtain these. (safety)
- Do listen to people who wish to share their stories and emotions and remember there is no wrong or right way to feel (calming).
- Do be friendly and compassionate even if people are being difficult (calming).
- Do provide accurate information about the disaster or trauma and the relief efforts. This will help people to understand the situation (calming).
- Do help people contact friends or loved ones (connectedness).
- Do keep families together. Keep children with parents or other close relatives whenever possible. (connectedness)
- Do give practical suggestions that steer people towards helping themselves (self-efficacy).
- Do engage people in meeting their own needs (self-efficacy).
- Do find out the types and locations of government and non-government services and direct people to services that are available (hopefulness).
- If you know that more help and services are on the way do remind people of this when they express fear or worry (hopefulness)

**DON’T:**

- Don’t force people to share their stories with you, especially very personal details (this may decrease calmness in people who are not ready to share their experiences).
- Don’t give simple reassurances like “everything will be ok” or “at least you survived” (statements like these tend to diminish calmness).
- Don’t tell people what you think they should be feeling, thinking or doing now or how they should have acted earlier (this decreases self-efficacy).
- Don’t tell people why you think they have suffered by giving reasons about their personal behaviours or beliefs (this also decreases self-efficacy).
- Don’t make promises that may not be kept (un-kept promises decrease hope).
- Don’t criticise existing services or relief activities in front of people in need of these services (this may decrease hopefulness or decrease calming).

(Source: Ursano et al., 2005)

See full handout in Appendix C.
The Strengths of PFA

Much of the research agrees that PFA has a number of key strengths which include:

- PFA is comforting to someone in distress and practical in that it endeavours to help people meet basic needs.
- PFA is immediate and intended to help those who recently experienced a disaster/event.
- PFA provides basic information-gathering techniques to help providers make rapid assessments of survivors’ immediate needs, thus assisting them to implement supportive activities in a flexible way.
- PFA has been built on evidence-informed strategies that are applicable in a variety of disaster settings.
- PFA takes into account developmental and cultural issues to ensure appropriate intervention for survivors of different ages and backgrounds.
- PFA can also provide information as appropriate if needed, and link people to necessary sources of information they require.
- PFA can be tailored to the needs and concerns of the affected person and their situation and includes handouts that provide important information for younger people, adults, and families for their use over the course of recovery.
- PFA can help those affected to link to family and other support persons, and to professionals, groups or aid providers should these be needed, as well as connecting them to supports and services who can help in the longer term.

Source: Adapted from NCTSN (2006)
**Summary: Recommendations for the Australian context**

**Be prepared:**
know the situation if possible, who your team members are and who is in charge, have a basic first aid qualification

**Assess & prioritise:**
assess the situation and prioritise need; don’t rush in

**Safety, security & shelter:**
ensure people are warm, protected, have fluid etc.

**Engagement:**
make contact, introduce yourself in a non-intrusive way, explain who you are and why you are there

**Calming & Comforting:**
‘be’ with people, acknowledge their situation, validate their thoughts and feelings, practical strategies (breathing, grounding techniques) to calm

**Practical assistance:**
What is their most pressing concern? How can you help with this? What information is available to them?

**Connecting to supports:**
including family, friends, neighbours and other social supports; agencies or relevant authorities

**Finding solutions:**
encouraging people to identify their needs and consider ways of meeting them, helping them to do this or find information/relevant people who can assist

**Moving on to assist others:**
ensuring that linkages have been established for the previous person and then moving on to, once again, assess for greatest need.

4. Some Special Considerations

a) Psychological First Aid: the importance of communication and information - what do people want, and what do they need to know?

The first level of communication is of course introducing oneself and one’s purpose as part of engaging with the person affected. Regardless of the particular operational model, most conceptualisations of PFA highlight the crucial role of communication and information dissemination immediately following an event. Clear, concise, and honest information will determine both individual and community confidence. From an organisational point of view, it is important to limit the number of people and messages to maintain clarity and calm. Messages should be succinct, accurate in terms of available knowledge and clear. There must be a regular flow of information from the earliest stages if possible and this should be maintained, updated, and available at frequent intervals. Information in relation to the persons concerns should be provided particularly in relation to their safety and well being and should be appropriate to their language and culture. In practice information provision should involve a two way process – be careful that it meets the person’s needs and is responsive to their queries and situation.

In terms of content, information should be constructive in supporting people to engage in concrete actions. If possible, information should be consistent in its messages across the community and also across all responding personnel. It should be accessible to the different literacy and understanding of different community groups. It is important when preparing and planning any communication strategy that leaders know their community and its cultural groups including methods to provide information in multiple languages and via a range of culturally appropriate outreach services/methods. The role of indigenous workers in any response and outreach program is important as is utilising available community networks and supports. Most importantly information should be honest and acknowledge what is known and what is not known at any one point in time.

Information tailored to the disaster and the possible physical and/or psychological consequences and (most importantly) strategies to access needed resources, and to cope, are important components of many individual, group and community interventions offered in the aftermath of disasters. People also seek quite specific information, such as how and where they can find out
about the wellbeing of family members, whether their home is safe, which hospital to find the injured. Brief, clear, concise and concrete messages should generally convey information about:

i. Where, when and how information that is specific as above can be found & accessed.

ii. The likelihood of recovery and resilience, while still validating people’s experience, suffering, courage in getting through this.

iii. The range of possible normal reactions to such experiences including post-trauma reactions which are understandable and expected

iv. Concrete strategies to assist recovery (eg. practical actions; social supports and networks; maintaining a healthy lifestyle with good diet, sleep etc., and promoting family communication and advice on issues that parents may face; linking to appropriate services etc.)

v. Guidance on when to seek and where to get further help (including practical needs, follow-up, mental health services)

Knowledge about information and communication, and how to access necessary material, is an important PFA competence in terms of knowledge and skills.

In terms of some of the fundamental goals of PFA (i.e. providing for safety, security and practical support) there are a number of key questions that survivors may have and responders need to be either prepared for or be able to assist in trying to find answers. Some examples include:

- How to find a loved one
- How to get shelter or access financial support
- If bereaved, what the procedures are and what support is available for body identification or handling of the body
- How to get regular medication; medical assistance

Assisting people in these cases may involve the PFA provider connecting families with special bereavement support workers or family liaison officers who will have more information on welfare and assistance, and processes about those missing or possibly deceased. Post disaster environments
may be chaotic and confusing and information may be unavailable or rapidly changing. Flexibility is required and responders need to be honest with survivors about what they know and don’t know but also demonstrate that they are willing to help them find out answers where possible. See NCTSN & NCPTSD (www.medicalreservecorps.gov/File/MRC_Resources/MRC_PFA.doc, p. 48, 2006) for an example of a useful information guide to handling missing persons, bereavement issues, death notification, and body identification. See also Australian guidelines (Chapter 13 in this volume).

Communication and Information Resources

PFA responders should be aware of their local, state and territory / national information and communication systems, and how these can be accessed. These can include emergency information through broadcasting, local information systems, police and other emergency services, web-based communication such as Facebook and Twitter, as used by Queensland police in the 2011 floods; text and internet messaging and websites (Taylor et al, 2011). Such communication and information can assist Psychological First Aid goals.

Seeking Information from Those Affected

While people affected by disasters will probably be registered by agencies tasked to do this, there are two important aspects of gathering information:

- Assessment of need, wellbeing and potential adaptation, i.e. are they likely to need further assistance? Now? Later?
- Documentation of contact; with whom; what was found, what was done, and potential follow-up if needed.

b) Personal support: What is it and how does it differ from PFA?

Personal support is generally seen as an extension of PFA and requires a common sense approach that is calm and assured. It utilises similar principles as PFA but is most commonly offered over time. For example, PFA is most appropriate for the immediate, short-term period whereas agencies offering personal support (eg. Red Cross) are more likely to return or re-visit survivors as part of the
help continuum. Personal Support is most commonly delivered by trained volunteer and community organisations. PFA and Personal Support are both about ‘being there’ and showing concern for people by actively listening, providing comfort and information, and referral if necessary. There are similar goals: links to practical assistance; recognising and facilitating adaptive strategies to address needs, give hope and enhance resilience.

Personal support is, as noted above, a potential support strategy that may follow-on from Psychological First Aid in the emergency.

It is a generic support program with basic principles of:
- “Being there”, through getting in touch
- Showing concern and identifying issues
- Active listening
- Comforting those affected
- Providing information
- If concerned, linking to clinical processes, screening, and possibly assessment and referral – potentially through the persons General Practitioner, or the Recovery Program.

A resource for Psychosocial Interventions has been developed by the International Federation of Red Cross and Red Crescent Societies (2009). This defines psychosocial support as “a process of facilitating resilience within individuals, families and communities” (p.25). It goes on to state that it aims to help people “bounce back” from crises and helping them to deal with such events in the future. It goes on to state that by “respecting the independence, dignity and coping mechanisms” it “provides the restoration of social cohesion and infrastructure” (p.25). It also discusses psychosocial well-being which is seen as a component of human capacity (knowledge, capability and skills); the social ecology of social connectedness and support, and culture and values. Psychosocial support aims to “protect or promote psychosocial wellbeing and/or prevent or treat mental disorder”. It is a general strategy however and puts in a 4 level ‘pyramid’ model: the base level (Level 4) covers basic services and security. The next level involves active psychosocial support and works to support community members and families. The next-highest level deals with mild to moderate mental health problems and provides individual family or group interventions whereas the most specialised services provide expert treatment for those with severe psychiatric conditions.
As noted above, the level of interventions focusing on basic needs and psychosocial support are most relevant for the current discussion.

All these strategies may overlap with and link into other broad and generic support programs as described in Level 2 strategy and Level 3 and other initiatives listed below.

**Level 2: Skills for psychological recovery (SPR) in the following weeks and months**

As discussed, Skills for Psychological Recovery (SPR, see Chapter 11 of this handbook) is an evidence-informed model that has been developed to facilitate recovery of people affected by recent disasters. Rather than a formal mental health intervention, SPR is an intermediate, secondary prevention model to teach people basic skills. For many people it will be enough. If SPR doesn’t help to alleviate distress as effectively as is needed, it is appropriate to refer for more intensive mental health assessment and intervention. Additionally, if serious issues are revealed in the initial assessment, immediate referral is required. For further discussion see the detailed section of Level 2 programs in Volume II.

Core components of SPR (Hobfoll et al, 2007) include:

- Gathering information and prioritising assistance
- Building problem-solving skills
- Promoting positive activities
- Managing reactions
- Promoting helpful thinking
- Rebuilding healthy social connections

These fit within the three level response framework discussed earlier and provide a continuum for those moving from a PFA framework to a more structured, interventionist approach. A detailed resource and training program is available from the Australian Centre for Post Traumatic Mental Health (http://www.acpmh.unimelb.edu.au/services/education.html). See the *Australian*
Level 3: More intensive mental health interventions (see also Chapter 12 of this handbook)

A small percentage of people will be at risk of developing significant mental health problems. These can include: PTSD, mood disorders: major depression, anxiety disorders, panic disorder (PD), traumatic / complicated grief, substance use disorders and psychosomatic complaints. Following a thorough clinical assessment, treatment with evidence-based clinical interventions, such as Trauma-Focused Cognitive Behaviour Therapy (TF-CBT) may be required (ACPMH http://www.acpmh.unimelb.edu.au/resources/resources-guidelines.html#1). For a detailed discussion of screening and assessment considerations and specialised treatment options for both adults and children, see the relevant chapters in this Handbook. A specific resource for the “Psychological Treatment of Common Mental health Problems after Trauma and Disaster” was developed in response to the Victorian bushfires of 2009, but for disaster broadly, based on available evidence by the Australian Centre for Post Traumatic Mental Health (http://www.acpmh.unimelb.edu.au/), with models for both adults and children. These are described in detail in Chapter 12.

It should also be noted that some people will have pre-existing mental health problems or illness that may require assessment and care, particularly if management has been disrupted, or they experience severe stressor exposures. Their condition may be further aggravated by the disaster experience.

Outreach systems and information dissemination

A great many people affected by disasters have no experience of accessing and utilising helping agencies (including mental health services) or of understanding why, when and where they should seek help. Many of those affected by disaster do not seek mental health advice or use services (North & Pfefferbaum 2002; DeLisi et al., 2003) and may feel stigmatised in doing so. After the WTC
attacks, there was only a 3% increase in general health service utilisation, only 10% reported increased mental health service visits after the attacks compared to prior use and a 5% reported decreased use (Boscarino et al 2002). Three to six months later, only 27% of those reporting severe psychiatric symptoms had obtained mental health treatment (DeLisi et al., 2003).

Given the lack of experience accessing helping agencies and often the stigma surrounding mental health services, the role of the general practitioner in disaster response is a key one. In addition to responding in the immediate aftermath, GPs form a fundamental part of ongoing community care and are most often the more trusted community members. In the immediate and short-term response phase following a disaster, many affected people may present to their local GP where they may raise issues to do with physical or mental health concerns. It may be more acceptable for people to talk to their GP about feeling overwhelmed or anxious than a mental health professional, the more so because many stress impacts may present with physical symptoms such as sleep or appetite changes, tiredness, body pains, losses of energy and so forth. Accessible information for GPs, effective liaison and systems of care are essential. An example of an initiative following the Victorian bushfires is at:

http://www.earlytraumagrief.anu.edu.au/health_general_practitioner/

**Follow-up over time**

As discussed, many do not seek help immediately following or subsequent to a disaster. For those involved it is important that they can be followed up if needed and monitored or at least kept informed of possible ways to seek support should they require it. Obstacles to this are often practical and can include issues of privacy, numbers of those involved and how and when to make contact. Experience working with survivors of the Bali bombing highlighted how difficult it can be to 1) contact those involved – details were restricted as part of privacy legislation and families were spread throughout Australia, 2) gain some kind of legitimacy as many did not have the desire or see the necessity of follow up, and 3) continue to monitor and follow up as the volume of those eventually seeking support can become significant. Information evenings can facilitate people’s knowledge about what is available, and also link them to support processes and others who have been through the disaster.
Contact with a caring, empathic PFA provider in the immediate and short-term response phase may at the very least leave the person with information and guidance on what to expect as part of a normal recovery. It may also legitimise contact with a health/allied health professional, resulting in a greater willingness to be followed up or to make contact in the future should it be required.

**Psychological First Aid and Disaster Responders: Implications for PFA training and evaluation**

A PFA approach aims to train responders to be sensitive to competing needs and the systems in place to address them at disaster sites. This is in balance with the personal challenges and demands that will be faced. The effects of working within a disaster environment can be many and varied for responders and there is research and literature on the stressors and potential impacts as well as the strengths (Raphael, Singh & Bradbury 1983; Benedek et al., 2007).

The WHO resource “PFA: A Guide for Field Workers” (WHO, 2011, Chapter 4) describes the following principles for those delivering PFA in disaster settings.

When preparing to help:

- Learn about the crisis, roles and types of different helpers, consider your own health or personal issues that may be sources of extra stress when helping others, and honestly evaluate your capacity to help in the particular situation.
- Manage your own stress so as not to become a casualty, maintaining healthy eating and sleeping habits; keeping reasonable working hours, and keeping in contact with sources of emotional support such as family, friends and colleagues / fellow helpers.
- When ending the helping role, take time to reflect and possibly talk with colleagues, acknowledging what was able to be done for those distressed and what was not; and if possible, rest before taking up regular work & life duties again.

Given that PFA can be delivered by responders from a variety of backgrounds including: health, allied health and specialist mental health services, non-government agencies and volunteer organisations, it is imperative that training is of high quality, standardised and accountable. A brief scan of the internet reveals a variety of (often private) organisations selling PFA courses. There is
little evidence that these training programs are standardised and guided by the guidelines (see NCTSN 2007) and types of consensus and research discussed earlier.

There is a small number of high quality training programs (see NCTSN, International Red Cross etc.) currently available for PFA for responders. However they vary in their level of clinical emphasis (eg. community-based volunteer workers vs specialist mental health professionals) and cannot be reliably compared. While all follow key PFA principles, some take a more generic personal support approach while others are more clinically focused. More research and experience in delivering and evaluating PFA training programs is needed (see Young et al., 2006). There is also the need to consider some of the existing training models and further explore developing these programs for delivery to a wider population of responders; particularly via the internet. A number of examples of this already exist. See the NCTSN PFA 6 hour online course (http://learn.nctsn.org/index.php).

The WHO PFA Guide for Field Workers contains 3 case scenarios with very specific settings such as natural disaster, violence and displacement, and accidents, tips for actions and behaviour, and sample conversations with people of different ages and circumstances. This resource provides these examples, as well as other valuable guidance for education and training.

As discussed earlier, there are also resources utilising the KEEP S.A.F.E model and particularly tailored it to CBRN responders (Stevens et al., 2008a&b & Raphael et al, 2008). See also Ng, Ma, Raphael et al. (2009) for a review of the Australia-China PFA training initiative following the earthquake in Sichuan.

**Self-care for responders**

Stories heard by those offering both PFA and personal support can range from inspiring and triumphant to the most horrifying and gruesome. While high-quality training provides a degree of confidence for professionals, it is difficult to know with certainty how a situation of mass disaster can impact upon those involved in any or all response phases. The sight of mutilated body parts, the cries of vulnerable children or the desecration after catastrophic bushfires, affect all at the most basic human level. It is important to recognise one’s own strengths and vulnerabilities, rely on and have confidence in what we know, and be aware and resourceful when we do not know. Aside from
the very real human spirit that evolves in such situations, it is essential that systems of support via colleagues and organisations are in place. Supervision, operational review / debriefing, monitoring of and standards for tours of duty (ie. work hours) and peer support are essential elements of a well planned and prepared response.

**Delivering PFA to vulnerable populations**

The aftermath of a disaster can have significant consequences for a variety of people and particularly those from vulnerable groups. These may include disaster responders themselves, people with a pre-existing physical or mental illnesses, children and adolescents, the elderly, previously traumatised, indigenous or people from culturally or linguistically diverse backgrounds (Neria, Galea & Norris, 2009 see Part 4, chapters 12-16; Silove 1993; Silove 1999). A comprehensive discussion of the particular stressors and impacts faced by these populations is discussed more comprehensively in other sections of this manual.

A brief overview of the guidelines and general principles of PFA for children and adolescents will be discussed below. A number of information handouts designed to assist responders in their work or to provide helpful information to survivors have been included as Appendices (see Appendix F Working with Older Adults). These are drawn from a variety of sources, most notably the NCPTSD, NCTSN and the PFA: Guide for Field Workers (WHO, 2011). All are of excellent quality and should be utilised in preference to a plethora of less rigorously tested information handouts freely available on the worldwide web.

**Psychological First Aid (PFA) for children and adolescents**

There have been a number of excellent studies following 9/11, Hurricane Katrina, and many other disasters of the stressors and impacts of disaster upon children (La Greca, 2006). The chapter on children and adolescents will deal more comprehensively with this research and a PPRR framework as it applies to younger people. Impacts upon children and young people will be determined by their developmental level and will vary from adults (La Greca 2002; and see review by Wooding & Raphael 2004). In terms of a PFA approach, the first priority for children and adolescents (as it is with adults) is safety and security. A PFA provider may need to consider the following variables when approaching and dealing with a child or adolescent:
**KEEPING SAFE FOR CHILDREN AND ADOLESCENTS**  
(Source: Wooding 2010 - adapted from Stevens and Raphael 2008a)

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<td>• Injured? Needing medical attention?</td>
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<td>• Protection? Ensuring safety both physical and psychosocial</td>
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</tr>
<tr>
<td>• With a caregiver or a known person? Are they safe with this person?</td>
<td></td>
</tr>
<tr>
<td>• Level of distress/symptoms</td>
<td></td>
</tr>
<tr>
<td>• Experience - disaster (eg. degree of exposure)</td>
<td></td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>• Immediate needs? Find family, pets, friends?</td>
<td></td>
</tr>
<tr>
<td>• Practical information? Information for shelter or for caregivers etc.</td>
<td></td>
</tr>
<tr>
<td>• Link with resources/ appropriate services?</td>
<td></td>
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</tbody>
</table>

This takes a comprehensive approach and follows the PFA process according to core principles.

The NCTSN and the WHO have also provided guidance on the best way to assist children in the aftermath of disaster and this information highlights interpersonal process and communication as key. Pynoos et al (2007), building on significant research findings, emphasise the role of Psychological First Aid in their overarching multi-level model of psychological care for children who have been affected by disasters. Other workers have also contributed significantly to this field, e.g. Ruzek et al (2007), Vernberg et al (2008).
Special Issues when dealing with Children

- Introduce yourself, your name, show your badge and let them know you are there to help
- Check who they are with. If family is present, or teachers, engage with them also. If not, ensure that they are safe in terms of caregivers, or if alone or uncertain, make sure they are looked after, or appropriate care is put in place, particularly for younger children and if alone.
- Check immediate needs, injury or not, safety, shelter, water, food, warmth, medical care and help to address these.
- Talk gently and directly to them, at their developmental and physical level, face to face, and use language that is simple and clear.
- Protect them from exposure to additional trauma such as gruesome scenes, people who are not part of the formal emergency response, and media or other agencies not responsible for their immediate safety and care.
- Engage them in play or other activities if appropriate, but ensure they are not too distressed. Older children may benefit from being involved in actions to look after younger children or deal with problems.
- Primarily link children to ongoing safety, protection and are, and family as the key priority.

Adapted from PFA: A Guide for Field Workers, WHO, 2011, p.34

The Three Steps of Psychological First Aid for Children, Adolescents and their Caregivers

As discussed previously, one of the strengths of PFA is that it can be delivered via a variety of modalities and this is particularly advantageous when working with children, young people and their families. For example, PFA providers can assist families to manage immediate or longer-term parenting issues via information and advice to caregivers. This is non-intrusive and aims to support families in their coping. One excellent resource from the UCLA Centre for Public Health and Disasters is a 3 step process/approach: ‘Listen, Protect, Connect’. See http://www.ready.gov/kids/_downloads/PFA_Parents.pdf
'Listen, Protect, Connect'

Information and education about common reactions, behaviour changes, and contributing factors

**LISTEN** – With your ears and eyes
Don’t force talking
Ask questions like:
What do you think has happened? What are you most worried about?

**PROTECT** – Keep the child safe, be patient, try and keep routines, monitor media

**CONNECT** – Reach out to family, friends, community resources etc.

(Source: PFA for Children, Parents and Caregivers after Natural Disaster Schreiber UCLA Center for Public Health and Disasters, 2006)

**Summary & Conclusions**

A brief summary of the key issues of this model and themes relevant to those who work in the field is provided in the WHO PFA: Guide for Field Workers Pocket Guide, and reproduced in Appendix D.

It has often been said that disaster is about normal people in abnormal situations. Despite the abnormal event or situation that may entail it, there should be no mystique surrounding the principles and delivery of Psychological First Aid following a disaster. PFA is a human process delivered to those in extremely distressing circumstances. It calls upon our basic human capacity to be empathic, caring, calming and supportive. It is practical, concrete and designed to help people solve problems in a collaborative, positive way. What do people need to do? How can we help or what do we do to support their survival and wellbeing, practically physically, psychologically and will recognition of and support for their own strengths and capacities. It is not prescriptive and, unlike
earlier immediate interventions, it aims to be non-intrusive and flexible by not forcing people to talk about their experience. Core principles and key skills have been discussed and a range of supporting literature that exemplifies some of these has been referenced or included in the Appendices for immediate use.

PFA is inherent in all stages of a PPRR approach. Comprehensive preparation and planning via training of responders should mean that PFA is delivered confidently and flexibly to a range of people across a range of disasters. While it should be remembered that PFA is still evidence-informed, current research efforts may soon be able to further validate key components for success in delivering PFA in the field and training responders in preparation for a disaster.

Two issues remain and should always be considered in balance. Firstly, that we will always face disasters in some form or another but that secondly, people are resilient and the majority will recover. PFA acknowledges the first and with its practical, flexible, humane approach aims to support and assist survivors to achieve the second.

This chapter has synthesised core principles as relevant for the Australian context. These should be to assess the situation to prioritise needs; make contact and engage with people; ensure their safety, security and shelter; being / staying with them and helping to calm and provide comfort; encouraging the person to identify primary needs and assist in meeting them or linking them to others who can help. Linking them to ongoing support in the form of family or friends is also crucial. The goal throughout is to draw upon the human compassion inside all of us: to acknowledge and validate people’s experiences, demonstrating genuine concern and caring, and respond in a way that is concrete and collaborative, while also supporting the capacities and strengths of those affected.
References & Resources

Australian Centre for Post Traumatic Mental Health. Australian Guidelines for the Treatment of Adults with Acute Stress Disorder and Posttraumatic Stress Disorder

Australian Psychological Society (APS) (2009). Guidelines for the provision of psychological support following the Victorian Bushfires.


National Child Traumatic Stress Network (NCTSN). Training in Trauma-Focused CBT
http://www.nctsnet.org/nccts/nav.do?pid=hom_main


Raphael, B. & University of Western Sydney. School of Medicine (2008). CBRN SAFE: chemical, biological, radiological & nuclear terrorism: psychosocial aspects & strategies: a review of the scientific literature / Beverley Raphael University of Western Sydney, Medical School, SCIMHA Unit, [Parramatta, N.S.W.]


- Model & Teach: Psychological First Aid for Students and Teachers
- Psychological First Aid for Children and Parents
- Family to Family, Neighbour to Neighbour: PFA for the Community Helping Each Other


Australian websites/resources

Australian Centre for Post Traumatic Health Guidelines
http://www.acpmh.unimelb.edu.au/

Australian Child & Adolescent Trauma, Loss & Grief Network (ACATLGN)
http://www.earlytraumagrief.anu.edu.au/

Australian Psychological Society (APS) http://www.psychology.org.au/

Australian Red Cross http://www.redcross.org.au/default.asp


Royal Australian and New Zealand College of Psychiatry (RANZCP)
http://www.ranzcp.org/

International organisations/resources


American Red Cross (children and disasters pages):
http://www.redcross.org/services/disaster/0.1082.0_602_00.html

British Psychological Society (BPS) http://www.bps.org.uk/

European Society of Traumatic Stress Studies: http://www.estss.org


International Society of the Red Cross (ISRC) http://www.icrc.org/

International Federation of the Red Cross and Red Crescent Societies http://www.ifrc.org/

International Society of Traumatic Stress Studies resources on terrorism and disaster: http://www.istss.org/resources/public.cfm

National Center for PTSD factsheet on disasters for survivors:
http://www.ncptsd.va.gov/ncmain/information/trauma/disaster/general_ndis.jsp

National Center for PTSD factsheet on disasters for mental health care providers:
http://www.ncptsd.va.gov/ncmain/providers/fact_sheets/trauma_type/type_disaster.jsp

The National Child Traumatic Stress Network (NCTSN)
http://www.nctsn.org/nav.do?pid=hom_main

UCLA Center for Public Health and Disasters http://www.cphd.ucla.edu/
World Health Organisation (WHO) [http://www.who.int/en/]


Online Resources

Appendices

Knowledge/Information based Handouts

Appendix A: Normal or expected reactions to an abnormal event
(DRRRG, 2010)

Appendix B: When terrible things happen: What you may experience.
(NCTSN & NCPTSD 2006)

Appendix C: PFA: Do’s and Don’ts
(Ursano et al., 2005)

Appendix D: PFA: Pocket Guide
(WHO, 2011)

Skills based handouts

Appendix E. Skills based Handouts

1. Approaching and dealing with a highly distressed person
(DRGGG, 2009)

2. Exercises to support calming
(WHO, 2011)

Appendix F: Working with older adults
(NCTSN & NCPTSD 2006)
Knowledge/information handouts

Appendix A - PFA Disaster Responder handout: Normal reactions to extreme stress
(DRRRG 2010)

<table>
<thead>
<tr>
<th>Common General Reactions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emotional:</strong> Fear, helplessness, grief, anger, arousal, being on edge, numb, disbelief</td>
</tr>
<tr>
<td><strong>Cognitive:</strong> difficulty concentrating, preoccupation, worry, images, memories, problems with decision making</td>
</tr>
<tr>
<td><strong>Social:</strong> social withdrawal, conflict, relationship problems</td>
</tr>
</tbody>
</table>

When assessing and responding, the ‘ABC of Triage’ may be of guidance in the acute phase:

**Arousal:** calm, relax, breathing or emergency care & sedation
**Behaviours:** monitor, calm, contain for safety, mental health assessment
**Cognitions:** advice, reality/protection, monitor for organic impairment

**Elements of the ABC approach are:**

**Arousal**

- Comfort and consoling
- Providing a sense of safety
- Reuniting families
- Keeping families together
- Identifying distressed survivors for early attention and support
- Providing basic needs

**Behaviour**

- Protect from harm due to high risk behaviours
- Link to support systems
- Redirect to constructive, helping behaviours
- Provide opportunities to gain mastery
- Encourage routine activities
- Educate survivors on adaptive behaviours
These may be elements included in a PFA approach which informs survivors of possible expected responses and also directs them to useful coping tasks.

**Cognition/Thinking**

- Communicate effectively
- Orient to the situation
- Clarify what happened
- Provide information for action
- Help survivor focus on reality
- Identify risks and resources

These principles may help and give guidance in the acute phase.
Appendix B

When Terrible Things Happen
What You May Experience

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

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

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

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

What Helps

Talking to another person for support
• Engage in positive distracting activities (sports, hobbies, reading)
• Getting adequate rest and eating healthy meals
• Trying to maintain a normal schedule
• Scheduling pleasant activities

Spending time with others
• Using relaxation methods (breathing exercises, meditation, calming self-talk)
• Participating in a support group
• Exercising in moderation
• Keeping a journal

Taking breaks

Seeking counseling

What Doesn’t Help

• Using alcohol or drugs to cope
• "Workaholism"
• Extreme avoidance of thinking or talking about the event
• Not taking care of yourself
• Excessive TV or computer games

• Withdrawing from family or friends
• Anger or violence

• Overeating or failing to eat
• Doing risky things

• Withdrawing from pleasant activities
• Blaming others
• Excessive TV or computer games

Appendix C – Psychological First Aid Dos and Don'ts
(Ursano et al 2005)

Uniformed Services University School of Medicine

Disaster Response Education and Training Project: Center for the Study of Traumatic Stress

PSYCHOLOGICAL FIRST AID: HOW YOU CAN SUPPORT WELL-BEING IN DISASTER VICTIMS

People often experience strong and unpleasant emotional and physical responses to disasters. Reactions may include combinations of confusion, fear, hopelessness, helplessness, sleeplessness, physical pain, anxiety, anger, grief, shock, aggressiveness, mistrustfulness, guilt, shame, shaken religious faith, and loss of confidence in self or others. There is consensus among international disaster experts and researchers that psychological first aid can help alleviate painful emotions and reduce further harm from initial reactions to disasters.

Your actions and interactions with others can help provide psychosocial first aid to people in distress. Psychological first aid creates and sustains an environment of (1) safety, (2) calming, (3) connectedness to others, (4) self efficacy—or empowerment, and (5) hopefulness.

**DO:**

- Do help people meet basic needs for food & shelter, and obtain emergency medical attention. Provide repeated, simple and accurate information on how to obtain these. (safety)
- Do listen to people who wish to share their stories and emotions and remember there is no wrong or right way to feel (calming).
- Do be friendly and compassionate even if people are being difficult (calming).
- Do provide accurate information about the disaster or trauma and the relief efforts. This will help people to understand the situation (calming).
- Do help people contact friends or loved ones (connectedness).
- Do keep families together. Keep children with parents or other close relatives whenever possible. (connectedness)
- Do give practical suggestions that steer people towards helping themselves (self-efficacy).
- Do engage people in meeting their own needs (self-efficacy).
- Do find out the types and locations of government and non-government services and direct people to services that are available (hopefulness).
- If you know that more help and services are on the way do remind people of this when they express fear or worry (hopefulness)

**DON'T:**

- Don’t force people to share their stories with you, especially very personal details (this may decrease calmness in people who are not ready to share their experiences).
- Don’t give simple reassurances like “everything will be ok” or “at least you survived” (statements like these tend to diminish calmness).
- Don’t tell people what you think they should be feeling, thinking or doing now or how they should have acted earlier (this decreases self-efficacy).
- Don’t tell people why you think they have suffered by giving reasons about their personal behaviours or beliefs (this also decreases self-efficacy).
- Don’t make promises that may not be kept (un-kept promises decrease hope).
- Don’t criticise existing services or relief activities in front of people in need of these services (this may decrease hopefulness or decrease calming).

For more information see [www.usuhs.mil/centerforthestudyoftraumaticstress](http://www.usuhs.mil/centerforthestudyoftraumaticstress)

WHO, 2011, reproduced with permission

Psychological first aid: Pocket guide

WHAT IS PFA?

Psychological first aid (PFA) describes a humane, supportive response to a fellow human being who is suffering and who may need support.

Providing PFA responsibly means:

1. Respect safety, dignity and rights.
2. Adapt what you do to take account of the person’s culture.
3. Be aware of other emergency response measures.
4. Look after yourself.

PREPARE

» Learn about the crisis event.
» Learn about available services and supports.
» Learn about safety and security concerns.

PFA ACTION PRINCIPLES:

LOOK

» Check for safety.
» Check for people with obvious urgent basic needs.
» Check for people with serious distress reactions.

LISTEN

» Approach people who may need support.
» Ask about people’s needs and concerns.
» Listen to people, and help them to feel calm.

LINK

» Help people address basic needs and access services.
» Help people cope with problems.
» Give information.
» Connect people with loved ones and social support.
ETHICS:

Ethical do’s and don’ts are offered as guidance to avoid causing further harm to the person, to provide the best care possible and to act only in their best interest. Offer help in ways that are most appropriate and comfortable to the people you are supporting. Consider what this ethical guidance means in terms of your cultural context.

**DO’S ✓**

» Be honest and trustworthy.
» Respect people’s right to make their own decisions.
» Be aware of and set aside your own biases and prejudices.
» Make it clear to people that even if they refuse help now, they can still access help in the future.
» Respect privacy and keep the person’s story confidential, if this is appropriate.
» Behave appropriately by considering the person’s culture, age and gender.

**DON'TS ✗**

» Don’t exploit your relationship as a helper.
» Don’t ask the person for any money or favour for helping them.
» Don’t make false promises or give false information.
» Don’t exaggerate your skills.
» Don’t force help on people, and don’t be intrusive or pushy.
» Don’t pressure people to tell you their story.
» Don’t share the person’s story with others.
» Don’t judge the person for their actions or feelings.

PEOPLE WHO NEED MORE THAN PFA ALONE:

Some people will need much more than PFA alone. Know your limits and ask for help from others who can provide medical or other assistance to save life.

PEOPLE WHO NEED MORE ADVANCED SUPPORT IMMEDIATELY:

» People with serious, life-threatening injuries who need emergency medical care.
» People who are so upset that they cannot care for themselves or their children.
» People who may hurt themselves.
» People who may hurt others.
APPENDIX E

Key skills for PFA providers

1. Approaching and dealing with a highly distressed person

2. Exercises to support calming

These handouts provide descriptions of generic skills that can be tailored to need in the post-disaster context. A range of excellent information and skills-based resources can also be found at the following websites from various leading organisations including:

http://www.ptsd.va.gov/professional/manuals/psych-first-aid.asp
http://www.acpmh.unimelb.edu.au/
Dealing with a highly distressed person

Dealing with a highly distressed person in a situation of extreme stress and/or uncertainty requires a calm and common sense approach. General guidelines for engaging with people in the acute phase are:

Guidelines for encountering a highly distressed person

• Observe safe practices by showing concern for your own safety first
• Remain calm and appear relaxed, confident and non-threatening
• Keep the situation stable until people have time and resources to regain their normal composure
• Refer the moment you feel you are out of your depth or unable to assist

Introducing yourself: Approaching a highly distressed person

• There is no set formula. How you approach a person will depend on the circumstances and their demeanour
• Assess the situation and trust your instincts
• REFER: ‘Is it OK if I get someone who can help you with this?’
• You will respond differently to each person and each person will respond differently to you
• Make clear that you are there to assist this person

Source: DRRRG, Medical School, UWS, 2009
Exercises to Support Calming

The following outlines some exercises that can help to calm, reduce distress.

The following relaxation, slow deep breathing techniques can help distressed persons to feel calmer. It is focused on good, deep breaths that can help the muscles relax and bring calm and focus to the mind. Taking a few moments to feel calm may help the person to think more clearly about the situation, what they need, what resources they have and what to do next.

Breathing Exercise

People can be asked to sit down, close their eyes.

• Put their feet on the floor and feel the ground/floor beneath their feet and supporting them.
• Breathe slowly and deeply.
• Continue for a few minutes.

Muscle Relaxation Exercise

• Aim to help the person to relax through tensing certain muscles, holding their breath for 5 counts, then breathe out, relaxing those muscles.

• This slow breathing and relaxation can address different muscles in the body in turn: toes, feet, legs, belly, hands (make fists), arms, shoulders and face.

• When it’s finished, the person should breathe deeply for a few more breaths and keep breathing slowly and deeply and feel the calm in their body and mind.

Simple Stretches:

• Simple stretches of your arms with associated slow breathing can also assist with calming
Appendix F: Working with Older Adults

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

Factors contributing to strength in the elderly include:
- Having effective coping skills (mature perspective, patience, faith, interpersonal skills)
- Having a supportive network of family, friends, neighbors, community groups, and organisations

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

In working with older adults, the PFA provider should keep the following in mind:
- Engage respectfully by introducing yourself and your role, and seeking their name, and how they would like to be addressed
- Speak clearly and directly, assessing priority, and need
- Don’t make assumptions based only on physical appearance or age, such as that a confused older person is senile. 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
• Check for urgent physical health or injury needs and link to necessary medical assessment / treatment
• Speak with the person, unless direct communication is difficult
• When you are unsure of how to help, ask, “What can I do to help?” and trust what the person tells you
• Where possible, enable the person to be self sufficient
• An elderly person with dementia or other psychiatric or emotional 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.

To provide effective assistance, you can check the following:

• Safety of the physical environment from the impacts and for them, particularly if disabled or very fragile
• Sensory: Ask specifically about his/her needs for glasses, hearing aids, or other medical devices.
• Assistance with Physical Tasks: activities of daily living
• Medications and Medical Equipment: Inquire about medications—ask if he/she has a list of current medications or where this information can be obtained. Make sure he/she has a readable copy of this information to keep during the post-disaster period. Ask about whether he/she needs medical equipment or supplies (for example, medications, oxygen and wheelchairs). Try to ensure that all essential aids are kept with the person.
• Advocacy/Monitoring: If available, contact relatives to insure safety, nutrition, medications and rest.
• Housing/Discharge: Help with plans for an older person who is going home or needs access to alternative housing.
• Follow-up: where needed and possible, it is useful to arrange a follow-up contact to assess that the person is managing the aftermath

Remember:

Talking “down” to an older person, interacting with them as though they are no longer competent or responsible, or able to be independent, at least to a degree can be psychologically damaging, and counteract the value of support, PFA or other good intent.