mentalhealth academy

Psychological First Aid

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Introductory

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Text

Written by
Mental Health Academy

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Psychological First Aid

This course is a comprehensive 10-hour program developed by Mental Health Academy in partnership with the Australian Institute of Professional Counsellors. The program's content is referenced from dozens of international, peer-reviewed publications in the areas of disaster relief, social support and critical incident counselling, and framed around the internationally accepted principals of the NCTSN Field Operations Guide.

About this course

This short course will equip you to successfully enter a disaster relief setting or situation of narrower-scale adversity, and offer Psychological First Aid, promoting safety, calmness, empowerment, connectedness, and hope to survivors. It assumes that you know the basics of sitting with someone in distress - that is, the counselling micro-skills - although many experienced disaster volunteers are not trained mental health professionals, and indeed, those who are will see that the skill set required to successfully offer Psychological First Aid is quite different from that needed in "regular" practice.

Chapter 1

Overview

Aims of the course

Upon successful completion of this course you will be able to:

1. Define Psychological First Aid, and explain what it aims to do;
2. Delineate its role within the broader scheme of disaster services;
3. Identify the parameters of effective Psychological First Aid: the who, what, when, where, how, and why of service delivery;
4. Know what actions to take to carry out the core principles of Psychological First Aid: those which promote safety, calmness, empowerment, connectedness, and hope;
5. Identify the factors that will facilitate successful entry into the disaster setting;
6. Assess whether:
   a. You possess the core competencies required to deliver Psychological First Aid, and
   b. You are ready to take on the responsibilities of providing that care in a field setting
7. Tend to your needs for self-care, including:
   a. Stress management
   b. Working through personal issues
8. Provide survivors with appropriate "fact sheet" handouts and other information to help them cope.

The year is sometime in the first half of the last century. The place is somewhere in the developed world. The disaster is one that will be repeated many times over in the coming decades: let's say it's a flood, whose rising waters have not only cut a wide swath of devastation as homes, businesses, and communities are submerged, but also caused death and widespread homelessness as those affected scramble to higher ground – usually with no more than the clothes on their backs. As a volunteer assisting survivors, you are a trained disaster relief helper: perhaps from the army, or possibly a member of the region's civil disaster team - if there is one. You know that your job is to work within a highly specified chain of command to make sure that people are rescued off rooftops and other last-resort places to the relative safety of shelters. You are experienced at the logistics of handing out food, water, and blankets. Once this is organised, you know that you have done your job well.

Fast forward to the current millennium. The place is now anywhere in the world. The disaster is the same, except possibly more devastating in its scope. The communities it affects are just as traumatised, but there is a difference. In the twenty-first century, there is common understanding among disaster experts and professionals that, just because people are safely housed in evacuation centres with food, water, a mat and some blankets, does not mean that your helping job is finished. In the current disaster scene, you need to know more than rescue and supply logistics, although those continue to be crucial. In today's world, there is general understanding that the mental health of survivors will be vulnerable, at least temporarily, and possibly permanently. So now you must tend to their mental health as well; you need to be trained in Psychological First Aid.

This short course will equip you to successfully enter a disaster relief setting or situation of narrower-scale adversity, and offer Psychological First Aid, promoting safety, calmness, empowerment, connectedness, and hope to survivors. It assumes that you know the basics of sitting with someone in distress - that is, the counselling micro-skills - although many experienced disaster volunteers are not trained mental health professionals, and indeed, those who are will see that the skill set required to successfully offer Psychological First Aid is quite different from that needed in "regular" practice.

What the chapters cover

The course material is contained in seven chapters. ***Chapter One (current)*** outlines the course aims, content and structure. ***Chapters Two and Three*** give an overview of Psychological First Aid: what it is, and what it is not, what its aims are, and how it sits within the community-wide picture of disaster services. There is a brief history showing the evolution from its inception to present-day modes of delivery. It also differentiates Psychological First Aid from mental health helping within a medical context, as Psychological First Aid is commonly carried out today in a community setting. Discussion is included on who needs such assistance: that is, who the main beneficiaries are. We look briefly at the literature on resilience: the question of who is likely to come through a disaster in relatively better shape, and what the protective factors are. If you wish to offer Psychological First Aid, you also need to know who delivers it, and where. To have the requisite competencies to deploy successfully to a field setting, you also need to know about the phases of disaster recovery and how to work in a multidisciplinary way within an Incident Command System; we include information on those topics. Finally, there are numerous barriers to delivery, and these are also addressed.

Chapters Four and Five delineate the core principles and actions of Psychological First Aid. The principles are about promoting five things: safety, calmness, self-efficacy (empowerment), connectedness, and hope. Eight core actions have been identified which allow disaster mental health volunteers to follow the principles. The actions are:

1. Contacting and engaging survivors
2. Tending to needs for safety and comfort
3. Stabilising survivors
4. Gathering information about needs and current concerns
5. Providing practical assistance
6. Connecting survivors with social supports
7. Giving information on coping
8. Linking survivors with collaborative services

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

Section Six examines issues of getting into the field: the setting where the Psychological First Aid will be delivered. Differences between mental health professionals' "regular practice" and the disaster response fieldwork are noted. There is an assessment: "Am I ready for this?" for would-be psychological first aiders to check whether they possess the core competencies for offering Psychological First Aid, and are ready to begin this sort of service. Reports from other mental health professionals who became psychological first aiders after disasters are an important addition to the text. The volunteers share what they experienced, and offer advice about what works in a contemporary disaster field setting. Thus, if you would do this work, you know what to expect. All of the first aider reports stress the ultra-importance of self-care, so there are sub-sections on stress management and working through personal issues.

Finally, many disaster relief experts stress the need to be able to give survivors – sometimes repeatedly, as they are in shock – information that will help them to stabilise themselves and cope. Thus ***Section Seven*** deals with handouts and "fact sheets" that you might like to have on hand to dispense as appropriate.

Going into a community - or region-wide disaster setting - or even a situation where tragedy has occurred to just a few individuals – may not be easy. As a disaster expert has noted, there are many challenges of uncertainty that occur with "mass catastrophe" (Raphael, 2007, p 330). On both individual and community levels, empowerment seems threatened by not knowing for sure which actions will best deal with the disaster and its consequences. Even highly appropriate actions cannot always resolve uncertainties, guarantee that the threat is over, ensure that there will be enough resources for

everyone, or dictate whom one can trust. The most potent uncertainties for those affected and their helpers go right to the basics of human existence: questions such as "Will I survive?" "Will my loved ones survive?" "Will we have a place to be (such as home, neighbourhood, or workplace)?" and "Will there be resources for us (such as food and clothing)?"

Critical to self-empowerment is that individuals and communities gain a sense of competence, which is developed through education, training, and practice beforehand. Such preparation – for both community members and responders such as psychological first aiders - helps to build the confidence and flexibility that is essential for dealing with any emergency (Raphael, 2007). This course is part of that preparation.

Course outline and content structure

Critical to self-empowerment is that individuals and communities gain a sense of competence, which is developed through education, training, and practice beforehand. Such preparation – for both community members and responders such as psychological first aiders - helps to build the confidence and flexibility that is essential for dealing with any emergency (Raphael, 2007). This course is part of that preparation.

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We turn now to Section Two for an overview of Psychological First Aid, how it has come to be what it is today, and how it fits into the broader schemes of community disaster services and mental health response.

Chapter 2

The Big Picture

Imagine for a moment that you are a survivor of a powerful cyclone. Let's say that you and all your loved ones managed to get out safely, but you arrived at the community shelter with only a backpack each of essential medicines, basic documents (such as your birth certificate and passport), and a few precious photos. There was no time to grab more. After the winds receded and you were allowed to go back home, you found that you could not. The cyclone rendered your beautiful home and all your possessions into a huge pile of rubble.

While you are grateful that you are not experiencing bereavement and that no one was badly injured, the plain truth is that you have nowhere to live and, as you find out in the ensuing days, nowhere to work. The building which housed your family business, along with thousands of dollars of stock, was also obliterated. Suddenly, you go from being an independent, prosperous, optimistic family to a dazed, exhausted, stressed group of survivors with a bleak sense of the future. You are dependent on civil authorities and disaster relief organisations for the most basic of supplies: water, a bit of food, and a few blankets, as you try to make yourselves comfortable on the school gymnasium floor. What are your needs? How do you feel? And what, in this situation, could happen for you to bring you and your family back to a "normal" (albeit new normal) existence as soon as possible?

In years past, with survival assured and your family together, your "needs" would have been defined mostly in terms of practical, material aspects: getting you immediate resources of food, shelter, and clothing, for example. Disaster experts and civil planners would have begun figuring out where you could be accommodated for the many months until your home, and probably many others in the community, could be re-built. They would also be generating a plan for that re-building. But tending to your emotional, psychosocial, and spiritual needs would have been strictly your domain.

With the advent of disaster mental health and the identification of PTSD (post-traumatic stress disorder), all that changed. Psychological First Aid was developed as a principal tool to use after an emergency, disaster, or other disruptive event. It now constitutes a crucial aspect of responding to and recovering from a destructive or disruptive event.

In this chapter, we offer an overview of Psychological First Aid as we examine what it is and is not, what it aims to achieve, and how it came to its current position in the broader context of disaster services and disaster mental health response.

Objectives

The objectives of this chapter are as follows. Upon successful completion of this chapter, you will be able to:

- Define Psychological First Aid and explain the importance of the basic standards it must meet
- Articulate four general aims of Psychological First Aid
- Name the chief milestones in the history and evolution of Psychological First Aid

- List three reasons why Psychological First Aid is preferable to either no psychosocial support or support in the form of Critical Incident Stress Debriefing (CISD)
- Explain the context of Psychological First Aid within the overall program of disaster services, and with particular reference to horizontal and vertical stratification
- Identify what is involved in each level of a "stepped" disaster mental health response, from Psychological First Aid through to specialised interventions delivered by psychiatrists.

What is Psychological First Aid?

A definition and some characteristics

Psychological First Aid is an evidence-informed modular means of providing psychosocial support to individuals and families immediately after a disaster, terrorist or traumatic event, or other emergency. It consists of a set of helping actions which are systematically undertaken in order to reduce initial post-trauma distress and to support short- and long-term adaptive functioning and coping. Based on the principle of "do no harm", it is provided increasingly by members of the general population, although mental health professionals are almost always involved as well (Ruzek et al, 2007; Brymer et al, 2006; The Australian Psychological Society and the Australian Red Cross, 2010).

It is common sense. Psychological First Aid includes basic common sense principles to promote normal recovery. These are actions to help people feel safe and calm, connected to others, hopeful, and empowered to help themselves, with access to physical resources, and emotional and social support. Psychological First Aid helps survivors to meet current needs; it promotes flexible coping and encourages adjustment. It is called "first aid" because it is the first thing that helpers might think to offer disaster-affected people, and it commonly occurs in the first days, weeks, and months after a disaster or other emergency (Australian Red Cross and Australian Psychological Society, 2010).

It meets basic standards. The principles and actions of Psychological First Aid meet four basic standards. They are:

1. Consistent with research evidence on risk and resilience following trauma (that is, evidence-informed)
2. Applicable and practical in field settings (as opposed to a medical/health professional office somewhere)
3. Appropriate for developmental levels across the lifespan (there are different techniques available for supporting children, adolescents, and adults)
4. Culturally informed and delivered in a flexible manner, as it is often offered by members of the same community as the supported individuals (Ruzek et al, 2007; Brymer et al, 2006).

It is community-based. Psychological First Aid is community-based (as opposed to occurring within the medical profession), and the programs are usually developed in consultation with the targeted community, with support being provided by members of that community. This tends to make it culturally responsive. It is low-cost, with the chief expenses being those of developing the training and public education materials. Being culturally sensitive and low-cost makes it sustainable. Because Psychological First Aid programs incorporate the traditional coping strategies of the community for which they are developed, they tend to build on the strengths of the culture.

The programs build the response capacity of people who, in a disaster, will be the family and friends of the survivors; appropriately, they will be the ones to whom survivors and those affected most often turn for psychological support. Psychological First Aid can be implemented by other than mental health professionals. The core skill is active listening, the skill at the heart of most therapeutic techniques, but also the first skill learned in any interpersonal or communication skills program. Participants in Psychological First Aid programs report that gaining listening skill improves not only their psychological supporting, but also their personal and professional relationships and communication (Jacobs, 2007).

It is designed for field delivery. Psychological First Aid can be found anywhere that survivors of trauma can be found: shelters, schools, staging areas, hospitals, and other community settings. It is designed for simple and practical administration in field settings (Ruzek et al, 2007), and even mental health practitioners involved in it acknowledge that offering support in the field is vastly different from doing it in their "regular" practice.

Linking in with yourself

Take a few moments to link in with your own experience of mass disruption, as both survivor and first aider:

You as survivor

- What is your experience of surviving a natural disaster, terrorist attack, or other disruptive incident?
- How many people were affected?
- What kind of help, if any, did you receive?
- How did the assistance, or lack of it, impact on your recovery from the event?

You as first aider

- Describe a time when you assisted someone (or perhaps multiple parties) through an accident or disaster of some sort. It could be anything from a natural disaster to coming upon a traffic accident to rescuing someone lost in the forest.
- How many people were caught up in the event?
- What kind of help were you able to offer (that is: was it practical assistance, giving needed information, or emotional support)?
- How well received was your help?
- How has that helping affected your desire to do Psychological First Aid?

Why do we need Psychological First Aid?

Disasters, both natural and human-made, can strike at any time; sometimes we get a warning, and sometimes we do not. It is estimated that being involved in a significant traumatic event which causes Post-Traumatic Stress Disorder (PTSD) will mean a lifetime of that event continuing to be prevalent for 60.7% of men and 51.2% of women (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Lifetime prevalence for being exposed to a natural disaster is about 20% (Briere & Elliott, 2000; Kessler et al, 1995). In a study of 60,000 disaster survivors, between 18% and 21% indicated "severe" to "very severe" impairment. The rate of PTSD occurring in survivors of technological and human-made disasters ranges from 29% to 54%, while rates of PTSD for natural disasters are lower: between 4 and 8% (Norris, Friedman, Watson, Byrne, Diaz, & Kaniasty, 2002). Some studies have found that impairment from being in a disaster can go on for years (Briere & Elliott, 2000; Crace, Creen, Lindy, & Leonard, 1993).

Clearly, disasters and emergencies are shocking events whose effects can stay with us for a long time, if not a lifetime. Ever since PTSD has been recognised as a disorder in the late 1970's (Australian Red Cross, 2010), there has been increasing acknowledgement on the part of both the medical profession and those involved with disaster response that the psychological wellbeing of survivors and disaster-affected people needs to be tended to as well as the physical aspects. Mental health experts generally agree that early intervention can prevent more serious mental health problems later. The same mental health and disaster response experts also assert that most people are resilient enough, especially if they are given psychosocial support in the immediate aftermath of a disruptive event, that they will

eventually go back to "normal" without additional, specialised mental health intervention, such as long-term counselling or psychiatric services (Norris, Friedman, Watson, Byrne, Diaz, & Kaniasty, 2002; Australian Red Cross, 2010).

Yet despite a widely recognised need to provide immediate help for trauma survivors, there is little research consensus about how best to assist individuals during those first hours and days after their experiences (Ruzek et al, 2007). The field of disaster relief has continued to be plagued by difficulties investigating the question of, "What intervention is best?" Emergency environments are chaotic by nature; thus, it is rarely possible to conduct the controlled research and evaluation that would clearly identify which interventions best offer psychosocial support after a disaster. Nevertheless, Psychological First Aid has wide popularity in increasing numbers of countries as the most efficacious method of assisting survivors in those first crucial hours and days after an event. Let us look at the events which have brought Psychological First Aid to this pre-eminent position.

The history and evolution of Psychological First Aid

As early as 1922, the War Office in the United States had recognised the need for support of its military personnel who were experiencing combat stress. Those setting up the programs for the soldiers acknowledged the need for the same five elements which have grown into today's Psychological First Aid. That is, they appreciated that the soldiers needed to be made safe, calmed, empowered, connected to loved ones, and instilled with hope. Nevertheless, the main criterion for success of the interventions was not relief of stress symptoms. Rather, it was whether the soldier could be made functional again, and especially, whether he could return to active duty. The War Office program was called BICEPS, because it included the elements of "brevity, immediacy, centrality, expectancy, proximity, and simplicity" (Main, 1989).

The term Psychological First Aid was first coined by Drayer, Cameron, Woodward, and Glass (1954) in a manuscript they wrote for the American Psychiatric Association on request of the U.S. Federal Civil Defense Administration. The purpose of the manuscript was to provide guidance for managing in the aftermath of community disasters. By the 1970s the principles and foundations of crisis (psychological) intervention were being utilised in disaster work with adults (Raphael, 1977; Farberow, 1978) and in 1988, similar interventions were being implemented with children (Pynoos and Nader, 1988). By 1990 emergency organisations such as the Danish Red Cross were applying the principles as a preferred model for early intervention following exposure to a traumatic event. The principles have continued to gain widespread international acceptance, culminating in their inclusion in international guidelines (Knudsen, Hogsted, & Berliner, 1997).

Along with the development of the principles that we now know as Psychological First Aid, there has been a form of early mental health intervention called Critical Incident Stress Debriefing, which became popular in the mid-1980s. It is a psychological treatment intended to reduce the potential for psychological un-wellness that arises after exposure to trauma, and has generally consisted of "one off" sessions of a procedure in which survivors, disaster-affected others, and even first responders are able to "debrief" or talk about the trauma that they have just experienced. A structured group model designed to explore facts, thoughts, reactions, and coping strategies, its origins can be traced to efforts aimed at maintaining group morale and reducing psychiatric distress amongst soldiers immediately after combat (Mitchell, 1997).

Debriefing has been routinely offered in a number of settings on an international scale, including for victims of mass disasters, or individuals involved in traumatic incidents in the workplace, such as police officers. It is founded on the belief that promptly talking through traumatic experiences will aid people in recovering from potential psychological damage. It is usually offered on a voluntary basis, but there are groups for whom it is compulsory following trauma, including bank employees in both the UK and Australia and some UK police forces. The assumption is that debriefing can prevent the onset of PTSD, and some have suggested that it might also prevent employees who developed PTSD after a critically traumatic incident from suing their employers (The Professional Counsellor, 2011). A typical debriefing process takes place in a session two to three days after the trauma. Although initially designed to be used in groups, debriefing has also been used on individuals, couples and families (Carlier, Voerman & Gersons, 2000; Rose, Bisson, Churchill & Wessly, 2009).

Psychological First Aid or Critical Incident Stress Debriefing: which is better?

Because crisis intervention strategies have become one of the most widely used time-limited modalities of treatment, they have also – inevitably - come under scientific scrutiny for their effectiveness.

What the research says about Critical Incident Stress Debriefing

A number of reviews of the post-trauma intervention literature have concluded that there is no evidence that Critical Incident Stress Debriefing (CISD) prevents long-term negative outcomes (Litz et al., 2002; Bisson, 2003; McNally, Bryant, & Ehlers, 2003; Watson et al., 2003). For example, in a recent study of a group debriefing intervention with military personnel on active duty, researchers found that soldiers rated their satisfaction with CISD as high and mental health outcomes at follow-up did not worsen as a result of CISD. There were no differences, however, among the subjects who received CISD, those who received stress education, and those who only completed a survey. Researchers were measuring behavioural health outcomes (including PTSD), depression, general well-being, aggressive behavior, marital satisfaction, perceived organisational support, and morale. Heart rate and blood pressure readings before and after the sessions did not indicate a change in physiological stress, and subjective ratings of distress did not change pre to post-session (Litz et al, 2002). Two studies of CISD reported a higher incidence of negative outcomes in those who received CISD than in those who did not receive an intervention (Mayou, Ehlers, & Hobbs, 2000).

The Norwegian Knowledge Centre for the Health Services did an analysis of thousands of studies (a meta-analysis) in 2007, and – based on 34 studies that met its criteria for inclusion in the analysis - concluded that there was no effect of debriefing compared to no intervention during the first year after accidents and crises (Kornor, Winje, Ekeberg, Johansen, Weisaeth, & Ormstad, 2007).

There may be many possible explanations for why studies on CISD have resulted in negative or neutral findings, such as that the one-off intervention is too brief, or that it may increase anxiety. Nonetheless, many mental health experts are concerned that any intervention focusing on emotional processing right after a traumatic event may be harmful. Certainly, there has always been the controversy with debriefing: to whom should it be offered: survivors alone? Affected families? The responders who witnessed terrible sights in the course of rescuing people? And should people be made to talk about their experiences, or merely invited?

Accordingly, the general conclusion of those working in the field of mental health disaster response is that more research is needed before CISD should be routinely recommended in the immediate aftermath of a disaster (Watson, 2004). This seems especially sensible in view of how chaotic a post-trauma environment is, and how crucial it is to attend to pragmatic material needs, cultural and bereavement issues, and also the widely disparate needs of survivors as they go through recovery (Watson et al, 2002).

What's your view?

Some experts believe that focusing on emotions right after being involved in a traumatic event could be harmful. Do you agree? If you were the survivor of a traumatic incident, would you want to process your emotions right after the event? Why or why not? How might it be harmful, if you did?

How Psychological First Aid is different from CISD

As we will see, Psychological First Aid takes a very different tack from CISD, being very practically focused, and operating with the assumption that most people are resilient, and will recover well from a traumatic event if they are given basic support. In distinguishing Psychological First Aid from Critical Incident Stress Debriefing, it is important to note that Psychological First Aid is not about debriefing. It is not about minimally-trained field volunteers trying to obtain details of traumatic experiences and losses from survivors or responders, especially because such volunteers may not know how to respond to people making traumatic disclosures.

Because Psychological First Aid is often offered by community members whose main occupation is other than mental health, it is not about treating a "patient" or about labelling or diagnosing a person. It is not counselling, and as stated above, it is not something that only professionals, such as psychologists, counsellors, or psychiatrists, do. Similarly, it is not something that everyone affected by an emergency will need.

What Psychological First Aid promotes

Because disasters differ greatly from one another – as do the psychological reactions of the individuals, families, and communities who experience them – any model for intervention needs to be flexible, and adaptable to specific circumstances. The five principles which we know today as the framework for Psychological First Aid were first outlined by Hobfoll and his colleagues (2007), who declared that any psychosocial support in the hours and days following an emergency or mass catastrophe needed to promote:

1. safety
2. calmness
3. self-efficacy (self-empowerment)
4. connectedness
5. hope

Chapters Three and Four look more in-depth at these five core principles and the eight core actions that spring from them. These elements have provided a skeleton for developing the public health approach to disaster response that has been incorporated into a number of emerging Psychological First Aid programs (Benedek & Fullerton, 2007).

What are the aims of Psychological First Aid?

You may have heard the question of whether it is better to give someone a fish, or to teach them how to fish. Psychological First Aid does both in a way, but it is clear that exceedingly hungry people need to eat a bit of fish before they can focus on fishing lessons. So PFA addresses practical concerns first: the distribution of food, water, and shelter, to survivors, and the reconnecting of them to loved ones and others who have also been displaced (the fish). But along with identifying the needs of people caught up in an emergency, PFA attempts to build capacity in the disaster-affected, helping people find within themselves the strengths and abilities to meet their own needs (the fishing lesson).

This is a central impetus in providing psychosocial support, because the resilience literature, such as positive psychology, has shown that merely having a belief in one's ability to cope helps one to do so better. That is, people who are optimistic and who have some trust in the essential benevolence and predictability of life, or who show other hopeful tendencies, do better after experiencing a community disaster than those who believe that life is dangerous or inherently harmful, and not to be trusted (Seligman, 1992, Australian Red Cross and Australian Psychological Society, 2010; Carbonatto, 2009).

Link in with yourself

How optimistic are you? Martin Seligman, founder of the Positive Psychology Center, has developed a quick way of determining how optimistic a person is (and therefore, perhaps, how resilient). It consists of the three p's of your explanatory style: permanent, pervasive, and personalisation.

- ***Permanent:*** When bad things happen, how permanent do you assume that they will be (optimists tend to think that the setback is just temporary, like the person who loses his job, but is certain that he will quickly find another)?
- ***Pervasive:*** How specific versus spread over your entire life do you believe the effect of the terrible event is (optimists believe that the event will only be limited to one particular aspect of their lives, and not affect other parts: the person who loses their house, but focuses on how grateful they are to still have their family, for example)?
- ***Personalisation:*** Do you generally believe that it is yourself or others who are to blame when bad events occur (optimists don't blame themselves: for example, the person who "knows" they did a good job at work but lost their job because of the economic downturn). (Seligman, 1992)

Expanding out the five core principles of PFA, we can identify the goals of Psychological First Aid as including efforts to:

- "calm people
- reduce distress
- make people feel safe and secure
- identify and assist with current needs
- establish human connection
- facilitate people's social support
- help people understand the disaster and its context
- help people identify own strengths and abilities to cope
- foster belief in people's ability to cope
- give hope
- assist with early screening for people needing further or specialised help
- promote adaptive functioning
- get people through the first period of high intensity and uncertainty
- set people up to be able to naturally recover from an event
- reduce the chance of post traumatic stress disorder."

(Australian Red Cross and Australian Psychological Society, 2010, p 11).

A note on those who spontaneously debrief

Given that the above aims do not include encouraging people to open up about their experiences right after a disaster, there is the lingering question for those offering Psychological First Aid of how to deal with someone beginning to spontaneously talk about what has just happened to them. The general guideline is to provide a disaster-affected person with support, but not in a way that encourages them to discuss more than they want, which could be harmful and re-traumatising, especially if badly handled. In any case, field settings are not clinical ones, and attempting to have a clinical session or do psychological assessment within such a setting would be inappropriate. Those who seem to be at risk (showing marked signs of psychological distress) should be referred to formal mental health services (Australian Red Cross and Australian Psychological Society, 2010).

Assessing the effectiveness of Psychological First Aid

Reading the above list of aims as a possible provider of Psychological First Aid, how comfortable are you that you would be able to enter a disaster setting and achieve these goals? Even if you are a seasoned psychological first aider, there is the important question of how you (or anyone assessing your work) would know whether your service was effective at achieving what it set out to do. Many disaster and mental health experts have commented on the difficulty of evaluating Psychological First Aid: "Although there is strong consensus internationally that Psychological First Aid is the intervention of choice in the immediate aftermath of disaster and trauma, there is little published work seeking to evaluate its effectiveness." (Forbes et al, 2011). Let's look at why that is so.

It's complicated: the challenges of evaluating Psychological First Aid

To date, there are few published randomized controlled trials of Psychological First Aid during the first 14 days following disaster, mass violence, or other trauma. It has been difficult to develop definitive research-based recommendations for it, partly because a clear conceptual framework has been lacking, but beyond that, there are numerous difficulties in obtaining clear results from the field:

1. Because Psychological First Aid attempts to tailor the support offered to individual (or family or community) need, it is hard to use standard protocols, which means that it will be difficult to objectively document intervention in any given case (Ruzek et al, 2007);
2. Most disaster-affected people will recover from their experience without developing serious mental health problems, so very large numbers are necessary in order to demonstrate that the Psychological First Aid following on from a critical incident had a significant impact on survivors' adjustment (Forbes et al, 2011);
3. Even if disaster experts all agree that a certain helping approach post-disaster is the "right" one – the recommended best practice - for a particular setting, delivering the intervention in the (chaotic) field means that evaluators cannot be sure that the actions taken were faithful to the theoretical model being followed;
4. Many aspects, including cultural, organisational, and environmental factors, may significantly affect perceptions of and receptivity to Psychological First Aid types of interventions; it is difficult to assess the effect of these factors;
5. Crucial to successful evaluation is the ability to measure what was achieved relative to what a program or intervention was trying to achieve. In the "heat of the moment", the goals of interventions may not be stated clearly enough, or even agreed upon, prior to implementation; thus any subsequent evaluation is not meaningful (Forbes et al, 2011).

Despite the difficulties in formally evaluating Psychological First Aid, recent literature on the effects of disasters on mental health functioning has reached a general consensus that:

- It's not appropriate to pathologise people's reactions, or even to regard them as responses that will lead to later disorders;
- Many people will have stress reactions in the aftermath of mass violence – sometimes even years later; many of these reactions are transient;
- Rather than clinical diagnosis and treatment, many people post-disaster are likely to need support and the provision of resources (such as food, shelter, and information) to help ease the transition to normalcy;
- Even though most individuals will emerge psychologically intact after a traumatic incident, some survivors may experience high levels of distress and require community and at times clinical intervention (Galea et al, 2003).

Given all of the above factors, Psychological First Aid may meanwhile continue to be more "evidence-informed" (that is, developed from professionals' best guess about what the best practice is, given related studies that have been conducted) than "evidence-based" (meaning, adhering to insights gleaned from actual studies of Psychological First Aid in actions that were carried out).

PFA within the broader scheme of disaster and mental health services

How does any contribution you might make as a psychological first aider fit into the total picture of support received by disaster-affected individuals, families, and communities? Let's say that you are a mental health professional who has just learned of a terrible disaster in a nearby state. Your long-latent desire to go help out after a huge catastrophe seems finally at hand. Making the necessary arrangements, you are taken to the setting where the tsunami/bushfire/flood/cyclone has just hit. You step out of your plane/bus/boat/car and survey the scene; it looks like a war zone, with survivors sitting in a dispirited daze and helpers scurrying around everywhere. What do you understand of the very purposeful activity going on (probably frenetically) around you? How do you fit in with what is happening on the scene in a way that actually helps the situation and doesn't harm anyone? Two concepts that might help you pinpoint where your service comes in are those of horizontal and vertical stratification. Let's look at what they refer to.

The services needed now: horizontal stratification

In a disaster relief context, Psychological First Aid is one component of a broad spectrum response to disaster-related problems and needs. Some of the needs arise and can be met immediately, in the acute phase of the disaster, and others persist longer-term, sometimes even for years. Horizontal stratification refers to efforts to develop integrated, wide-ranging supportive services at the acute stage. Psychological First Aid is one of a variety of these coordinated interventions, along with food, medical services, social services, shelter, and even pastoral care, which are offered all together, as needed, to promote recovery in the first hours, days, and weeks after a disruptive event or other emergency.

When it appears as part of horizontal stratification, Psychological First Aid has two chief goals:

- To directly facilitate survivors' abilities to adaptively cope with acute stresses and acute stress reactions through the five core principles named above (promoting safety, calmness, empowerment, connectedness, and hope);
- To link survivors to other available services. During the Psychological First Aid phase of information-gathering regarding current and anticipated needs, Psychological First Aid and the collaborative services with which it is linked attempt to provide continuity of care across multiple domains of current need. The precise basket of offerings will depend on survivors' particular individual circumstances, and associated strengths and needs (Ruzek et al, 2007).

Psychological First Aid in the longer term: vertical stratification

Vertical stratification, in contrast, involves efforts to interlink individuals receiving Psychological First Aid with other, more specialised mental health services over time. As noted above, available evidence suggests that the majority of individuals exposed to traumatic stress do not generally develop persisting mental distress or mental disorders (Norris et al, 2002; Australian Red Cross, 2010). Thus, conceptual frameworks, risk identification methods, and intervention programs are needed to identify those at-risk for persisting severe distress and dysfunction, and to provide them with appropriate interventions at specific points in time when they are needed in the short, intermediate, and long-term aftermath of a disaster.

Vertical stratification interventions, for example, can:

1. identify populations of individuals who are at-risk for exposure to specific traumatic stresses;
2. help to prevent the traumatic stress where possible before that stress occurs;
3. promote stress resistance in those likely to be exposed before it occurs;
4. encourage resilient recovery among those adversely affected shortly after stress has occurred;
5. promote long-term protracted recovery in adversely affected subgroups that do not show resilient recovery, with the goal of preventing persisting severe distress and functional impairment (Layne, Warren, Watson, & Shalev, 2007).

The Victorian disaster mental health response

An example of what vertical stratification looks like in action can be seen in Victoria's stepped-care model of service delivery for mental health post-disaster. Attempting to scope how prepared its workforce was for offering mental health response after a natural or other disaster, the Emergency Response Group outlined its three-level approach, consisting of Psychological First Aid as Level One, Skills for Psychological Recovery (SPR) as Level Two, and Intensive Mental Health Treatments as Level Three. Here is what each level looks like in detail:

PFA (Level 1)	SPR (Level 2)
Purpose Population level support of common distress responses in the immediate aftermath	**Purpose** Support of individuals with mild to moderate sub-clinical levels of distress
Core Principles: 1. Promote Safety 2. Promote Calming 3. Promote Self-efficacy 4. Promote Connectedness 5. Promote Hope 6. Promote Help	**Modules:** 1. Gathering information and prioritising assistance 2. Problem-solving skills 3. Promoting positive activities 4. Managing reactions 5. Promoting helpful thinking 6. Rebuilding healthy social connections
Providers 1. Disaster relief workers 2. Community leaders 3. Generic workers	**Providers** 1. Primary care providers including: General practitioners, allied health, counsellors, and welfare staff

Intensive mental health treatments (Level 3)
Evidence-based Interventions: 1. Exposure treatments 2. Cognitive therapy 3. Goal setting/activity scheduling 4. Managing anger 5. Treatment of complicated grief 6. Managing co-morbidity 7. Pharmacotherapy
Providers Specialist mental health care staff including: 1. Psychologists 2. Psychiatrists

(Emergency Response Group meeting, 17 November, 2011)

Four levels of after-disaster care

Similarly, Ruzek et al (2007), in asking what services are needed and when they should be delivered, have developed a framework to provide continuity of mental health care with respect to short, intermediate, and long-term post-disaster intervention. Like the state of Victoria, they propose:

1. Psychological First Aid, the first level of post-incident care, delivered immediately after a mass disaster by community members trained specifically in that. Then, as acute distress reactions begin to subside in those individuals at lower risk, the second level would kick in for the at-risk survivors who are still experiencing stress.
2. "Secondary Psychological Assistance" (p 32), is similar in nature to Victoria's SPR (Skills for Psychological Recovery). It would also be a follow-up to the Psychological First Aid, and would contain interventions focused on psycho-education, developing and practicing coping skills, and a greater focus on promoting Psychological First Aid's core skills of calmness, connectedness, self-empowerment, and hope. Ruzek is clear that, at the level of SPR, assistance would require additional training to what those offering Psychological First Aid are able to undertake. Like Psychological First Aid, however, it could be offered in a variety of settings.
3. "Mid-level Enhanced Services" would be offered to those showing persisting signs of distress and dysfunction. Such services would focus heavily on psycho-education and building coping skills to help survivors deal with stress and anxiety reactions, while keeping negative effects at a minimum. Mental health professionals would generally offer it.
4. Trauma/Grief-Focused Therapy is the fourth level, comparable to Victoria's Level Three. It includes highly specialised treatment, which combines psycho-education and skills-building with explicit therapeutic exercises designed to decrease mental distress, facilitate adaptive grieving among the bereaved, promote adaptive coping, and facilitate moving on in development. Obviously, only specialists, such as psychologists and psychiatrists, would be trained to offer assistance at these latter two levels.

As with the Victoria model, the expectation is that a decreasing proportion of individuals will need assistance as one goes through the levels. Thus, many disaster-affected people would benefit from Psychological First Aid, fewer would require Skills for Psychological Recovery or Secondary Psychological Assistance, and only a fraction of those would need mid-level and highly specialised mental health treatments (Ruzek et al, 2007).

Summary

Advances in the fields of mental health and disaster response have shown that many if not most disaster-affected individuals can psychologically recover from the effects of a traumatic incident if they are given immediate, basic material and psychosocial support. There is consensus among experts, both in Australia and internationally, that Psychological First Aid is the preferred form of intervention for that support. This is in spite of the difficulty evaluating its effectiveness in the chaotic field environments in which it occurs. Offered in the acute phase of disaster aftermath (meaning, right after an event), Psychological First Aid promotes safety, calmness, empowerment, connectedness, and hope to survivors. It is offered along with other community and social services at that stage, and precedes more intensive mental health interventions that may be needed later for some individuals whose traumatic reactions persist.

Chapter Two fleshes out the details of a Psychological First Aid offering: who needs it and who offers it, where it is delivered, and what the protective factors are that determine resilience or risk when a disaster strikes. Chapter Two also outlines the phases of disaster recovery, and what it means for an Incident Command System to organise and manage a disaster response.

Link in with yourself

Take your mind back – if it does not traumatise you too much – to a time when something fairly shocking happened to you. For some people, it might be something like a car accident, or perhaps an experience of being lost or having everything stolen in a foreign country. Maybe you are thinking of something more serious, such as the horror of watching someone get hurt and being unable to do anything to prevent it. Whatever it is, tune into those first minutes and hours after the event, or as it was unfolding:

- What bodily sensations were you experiencing (e.g., racing heart, nausea or butterflies in your stomach, dizziness, sense of unreality, shallow breathing)?
- What emotions can you recall feeling (e.g., fear, dread, anger, panic, anxiety, shock)?
- What thoughts were going through your mind?

Now move forward in time to about a month after the event. What can you recall of your physical and mental wellbeing at that stage? Were your body-feelings-mind experiences from right after the event continuing at that stage? How aware were you of avoiding people, places, or things that reminded you of the trauma? Did you have a sense at the one-month mark that, although you had been shocked, you could now carry on with regular life, or did you find that your everyday functioning was impaired? Did you get any mental health help (such as through a counsellor or psychologist) for what you were going through?

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Chapter 3

A Community Effort

It's been an interesting half-hour walking around the overcrowded sports stadium-cum-shelter where evacuees from the bushfire are trying to make themselves comfortable with minimal supplies and no privacy. As a new Psychological First Aid trainee, you are asked to try to discern who in this small community needs help, and what help they need. As you scan the stadium, you spot several prospects for assistance. There is an older gentleman sitting on a mat over near the toilets. He looks frail, his eyes are glassy, and he appears to be talking to himself. Milling around the area where the water bottles are being distributed is a little girl, maybe three years old. You've been noticing her for at least 15 minutes, and no adult has stepped forward to claim her. She seems to be getting agitated, and you wonder if she is separated from her parents. In the corner there is a young woman silently sobbing; all of the disaster responders seem to be too busy with others to approach her. You wonder if she is the teenager they featured on the news yesterday, the one whose whole family is believed to have been incinerated as they stayed to defend their home; she was away when the killer firestorm came through, so here she is, alone.

Approaching each of the three confirms your hypotheses: the old man does not respond to you, and appears to be hearing voices; he will undoubtedly need more intensive assistance from the community mental health team. You've taken the little girl to the "Missing persons" desk, and they are already making announcements for her parents to come collect her. And you have helped the teenager to become coherent enough to say that she is grieving, terrified, and in need of foster care. As you begin to arrange that care, you silently recall what they said in your training: Psychological First Aid is truly a community effort.

In this chapter we draw on both research and the experience of seasoned Psychological First Aid workers to paint a fuller picture of how Psychological First Aid happens in a community: who needs it; who tends to recover better – or worse – after a disaster (that is, the question of risk and resilience factors); who in the community delivers Psychological First Aid, and where. We take you through the four phases of disaster recovery, explain the organisational system used by most modern disaster relief management, and explore some of the barriers to effective delivery of Psychological First Aid.

Objectives

Upon successful completion of this chapter you will be able to:

- Identify the main candidates for Psychological First Aid
- Name at least six factors that put people at elevated risk for traumatic reaction after a disaster or emergency
- Name at least six factors which tend to increase resilience after a person has experienced a serious adversity
- Recognise the symptoms of trauma in a survivor or disaster-affected person

- Explain who should deliver Psychological First Aid, and where
- Name the four phases of disaster recovery
- Identify three barriers to offering Psychological First Aid in a field setting

Who can benefit from Psychological First Aid?

The short answer to this question is "everybody". Everyone who is exposed to a mass catastrophe, emergency, or other trauma is potentially capable of feeling threatened and stressed immediately, and also developing Post Traumatic Stress Disorder (PTSD) and/or other mental health disorders later.

The chemistry of trauma

When someone faces a threat, their body responds by producing neurotransmitters and hormones. The sympathetic nervous system tells the body to begin a "fight or flight" response by increasing respiration and heart rate, and releasing chemicals, such as adrenalin and glucose. As the disaster-affected person, still feeling vulnerable and afraid, attempts to make sense of what has just happened, the body often stays in a state of high alert, ready to adapt to any oncoming threat. This physiological state can result in sleep difficulties, loss of appetite, hypervigilance, anxiety, irritability, and concentration difficulties. There can be memory disturbances and intrusive experiences, where the traumatic event comes to mind unbidden and repeatedly (Warchal & Graham, 2011). Obviously, people in this heightened state of arousal find it difficult to make decisions, tackle the maze of paperwork required to begin accessing aid resources, and generally respond normally to events (such as the need to look after children). This is a good entry point for the psychological first aider offering assistance.

It is not only survivors of disasters and trauma who experience the physiological symptoms of high alert, however. The anxiety for those close to survivors, and the heightened pressure to "perform" well in a life-or-death situation mean that family and friends of survivors and also first responders are all exposed to the traumatic incident – if only secondarily – and might also benefit from Psychological First Aid.

Who may be at greater risk for traumatic reaction?

Many field guides, community-produced handouts for Psychological First Aid, and indeed, some of the academic articles on disaster (World Health Organization, 2011; Weisaeth et al, 2007; Brymer et al, 2006) declare that certain subgroups of a community are more vulnerable to a severe traumatic reaction than others. The at-risk groups have generally included children, the medically ill (including both physical and mental un-wellness), pregnant women, and older adults.

There has been a widespread assumption in the disaster literature that most adults who are caring for children, the mentally ill, or older adults will only experience mild, transient trauma reactions, which will pass without them receiving any special mental health support. While that may be generally true, it is important to remember that caregiver adults have emotional and physical needs, too, even if these are often overlooked (Warchal & Graham, 2011).

Conversely, older adults are often assumed to carry an elevated risk of traumatic reaction, but a number of studies have shown that, when compared with other age groups, older people are more resilient and less susceptible to the psychological and physical health effects of disasters (Bolin & Klenow, 1982; Huerta & Horton, 1978). One reason suggested for the extra resilience of the older adults (meaning here, those over 75) is that they have greater life experience – that is, higher numbers of past resolved stressful experiences – than younger people. For example, some of the people who are currently seniors have lived through at least one world war, and also the depression of 1929 and ensuing years. Moreover, they tend to have fewer current unresolved stressful experiences (Phifer, 1990).

Age, however, is far from the only factor which determines how resiliently or not we will respond to adversity. Often Psychological First Aid field guides try to alert volunteers to the many factors which carry a higher probability of mental health problems after a disaster. Commonly included on the lists are:

- Exposure to a disaster of great magnitude and/or long duration
- Being exposed first hand to grotesque scenes or extreme life threat
- Previous and/or repeated exposure to similar critical experiences
- Being in a high degree of personal danger and/or thinking that one is going to die
- Being acquainted with victims who died, or experiencing other traumatic bereavement
- Coming from a cultural background or traditions which tend to respond poorly to disaster
- Having a personal or family history of mental health issues or emotional instability
- Ostracism by co-workers, family, or the general public
- Having a recent tragedy in one's life
- Experiencing disruption to communities and networks
- Having to deal with media interference

(Australian Red Cross and Australian Psychological Society, 2010; (World Health organisation, 2011)

In addition to the above situational factors, there are individuals that are at special risk after a disaster:

- Children, especially those:
  - Separated from parents/caregivers
  - Whose parents/caregivers, family members, or friends have died
  - Whose parents/caregivers were significantly injured or are missing
  - Involved in the foster care system

- Those who have been injured
- Those who have had multiple relocations and displacements
- Medically frail children and adults
- Those with serious mental illness
- Those with physical disability, illness, or sensory deficit
- Adolescents who may be risk-takers
- Adolescents and adults with substance abuse problems
- Pregnant women
- Mothers with babies and small children
- Disaster response personnel
- Those with significant loss of possessions (for example, home, pets, family, memorabilia

(Brymer et al, 2006)

Not at-risk, but needing support now

Obviously, some individuals are not just "at-risk" (meaning, that there is a strong chance that they will need medical support in the future), but they need to be given attention right now. We will explore this group more extensively in a moment, but note that, at least, those individuals include people who are seriously injured and needing emergency medical care, survivors that are so distressed that they are unable to perform the basic activities of daily life (such as feeding themselves or making simple decisions), or disaster-affected people threatening harm to themselves or others (Australian Red Cross and Australian Psychological Society, 2010).

Linking in with yourself

If you are interested in pursuing work as a provider of Psychological First Aid, you may soon be making assessments of others' level of risk. Spend a few minutes now practicing risk assessment with respect to the most difficult assessment of all: the one on yourself. Go back to the factors above and see how many of them apply to yourself: the "you" that you are today (meaning: presumably not a person who has survived a disaster in the last several days, although you may have survived one in the past). Consider each factor in both lists and decide whether, if you were a psychological first aider providing help, you would assign someone like yourself a "low", "medium" or "high" at-risk rating. Consider especially:

- Which factors seem to have the strongest impact on you?
- Which factors, if any, are amenable to change and/or "fading" over time?
- Which factors are relatively enduring in their capacity to put you at risk?
- What treatment/advice/referrals would you make to a person like yourself?

The Conservation of Resources (COR) Theory

The risk factors and at-risk populations noted by all of these guides are consistent with the Conservation of Resources (COR) Theory (Hobfoll, 1989), which argues that loss of resources reduces options and results in psychological distress. Resources can be external, such as money, time, skills, social relationships, and possessions, or they can be internal, such as personal characteristics like self-efficacy, control, or optimism. When the COR theory was first tested after Hurricane Hugo in the United States, resource loss was positively associated with psychological distress, outweighing demographics or coping variables. When the COR theory was tested for a second time, the researchers

controlled for other variables (such as in the lists above) which tend to predict psychological distress. This time it became clear that resource loss predicted psychological distress; higher levels of resource loss are strongly associated with mild to moderate increases in psychological distress. The COR theory supports the "dose-response" relationship between low-magnitude life events, resource loss, and psychological distress. That is, people experiencing more low-magnitude life events (i.e., repeated exposure to, say, news reports of a disaster as opposed to being in the disaster) and more disaster-related resource loss were most prone to report current psychological distress (Freedy et al, 1994).

Post-disaster resilience: who survives better?

In recent years, many disaster response experts and mental health researchers have switched their focus from looking exclusively at at-risk populations in the aftermath of an emergency to asking, "What are the protective factors?" "What situations, experiences, or personal traits help people to come through a traumatic incident with greater resilience?" First, let's clear what we mean when we use the word "resilience" in this context.

Resilience: a definition

Bonanno (2004) has defined adult resilience as

"the ability of adults in otherwise normal circumstances who are exposed to an isolated and potentially highly disruptive event such as the death of a close relative or a violent or life-threatening situation to maintain relatively stable, healthy levels of psychological and physical functioning as well as the capacity for generative experiences and positive emotions" (pp. 20-21).

While researchers admit that controlled studies to date have not conclusively shown all of the factors which may support a hardy response to adversity, there are nevertheless some factors which are widely held to be negatively correlated with PTSD and other post-disaster mental disorders, seeming to confer an aura of protection on survivors:

- An optimistic outlook and positive expectations
- Having coping skills gained from previous distressing events and experiences
- Receiving good social support from others
- Possessing emotional stability
- Being a disaster worker in environments that are less horror-filled and/or more rewarding
- Relatively light loss of resources
- Being provided with basic resources (food, water, shelter, emotional support) early on
- Having a strong moral belief system or spiritual holding
- The ability to return to "normal" life (i.e., reduce disruption) relatively sooner
- Having the opposite situation to the factors named above as creating potential for being at-risk
- Having a strong sense of cultural/racial identity

(Seligman, 1992; Carbonatto, 2009; Australian Red Cross and Australian Psychological Society, 2010; (Tummala-Narra, 2007; The Professional Counsellor, 2011)

Linking in with yourself

Let's extend the assessment on yourself. If you did not come up with an assessment on your degree of risk for mental health problems (see above), go back and do that now, before moving on to this stage of assessment. Now, knowing what your risk factors and level of risk are, take an analytical look at the factors in your life and personality that may be protecting you from having mental health problems in the future. Assume for the moment that you have just survived a disaster (let's say it was a cyclone); let's assume that none of your loved ones died either, but you have had to temporarily vacate your home to live in a shelter (where food, water, and blankets are provided), and will not be able to return to normal life routines for about two weeks. Consider each protective factor on the list with respect to yourself, and honestly answer:

- Would you have protection from this factor after exposure to a disaster?
- How many of these factors might you be able to change over the medium term (such as optimistic outlook)?
- What is your general sense of your level of "protection": low, medium, or high?
- What is your overall level of risk, factoring in these protective factors with the risk ones?

What does a post-incident stress reaction look like? Recognising the symptoms of trauma

Many mental health and other professionals in private practice have travelled to disaster destinations to offer their skills in the acute phase of a crisis, meaning in the days following events such as Hurricane Katrina, the Boxing Day tsunami of 2004, or the 2008 Chinese earthquake in Sichuan province. One common thread running through their reports is that helping out in a disaster is vastly different than sitting with people in the calm confines of a consulting room. One way in which this is especially true is that there is not an orderly line-up of people waiting their turn to see the doctor/therapist/counsellor at a prescribed appointment time. In fact, in a field setting, all of that is turned on its head, and the volunteer – whether a "professional" in regular life or not – is often tasked with searching out those who would receive assistance. Several helpers have commented that that aspect of field work is quite challenging, so it is crucial to know: how might you – possibly a seasoned mental health professional, or possibly not – go about recognising when someone is experiencing the symptoms of trauma?

Every emergency or traumatic experience is unique, and so are the myriad reactions that the survivors have. All of these stress reactions are possible:

1. physical symptoms (for example, shaking, headaches, feeling very tired, loss of appetite, aches and pains)
2. crying, sadness, depressed mood, grief
3. anxiety, fear
4. being "on guard" or "jumpy" (hypervigilance)
5. worry that something really bad is going to happen
6. insomnia, nightmares
7. flashbacks or scenes from the disaster coming back intrusively to mind
8. irritability, anger
9. impulsiveness (especially for adolescents, who may take unwarranted risks)
10. guilt, shame (for example, for having survived, or for not helping or saving others)

11. confused, emotionally numb, or feeling unreal or in a daze
12. appearing withdrawn or very still (not moving)
13. not responding to others, not speaking at all, being "shut down"
14. disorientation (for example, not knowing their own name, where they are from, or what happened)
15. not being able to care for themselves or their children (for example, not eating or drinking, not able to make simple decisions) (WHO et al, 2011; Ruzek et al, 2007)

Some people may only be mildly distressed or not distressed at all. As has already been noted, most people will recover well over time, especially if they can restore their basic needs and receive support, such as help from those around them and/or Psychological First Aid. However, people with either severe or long-lasting distress reactions may need more support than Psychological First Aid alone, particularly if they cannot function in their daily life or if they are a danger to themselves or others.

Note: *It is vital to make sure that severely distressed people are not left alone.* It may be up to you as the psychological first aider to try to keep them safe until the reaction passes or until you can find help from health personnel, local leaders or other community members in the area.

Who delivers Psychological First Aid?

If reading thus far has piqued your curiosity and heightened your interest in becoming a member of this elite corps of hugely humanitarian helpers, your natural question might be, "So who can deliver Psychological First Aid?" which might really mean, "Could I deliver Psychological First Aid?" And the answer is: there is good news and bad news.

Doing Psychological First Aid: the good news

There is consensus among mental health and disaster response experts that, because Psychological First Aid is practically-focused, is not therapy, and is a community (as opposed to health profession) effort, many non-professional helpers, as well as mental health and other professionals, can get in on the act. Along with health and allied health professionals, teachers and other education professionals, members of the clergy and other faith-based organisations, local government staff, emergency personnel, trained responders, support volunteers, and even neighbours of disaster-affected people can and should offer the help, comfort, and support of Psychological First Aid to those who are in distress.

Obviously, some of the above groups – such as the mental health professionals – have extensive training in responding to traumatised people. Others, such as disaster response team members and other emergency personnel and those who have undergone specific preparation for their roles have some (possibly very brief) training in how to offer emotional support. Your next door neighbour who comes to help out may have no training at all. The principles of Psychological First Aid mean that that is ok. It can be offered by a wide variety of people in the community. But, if you were thinking of casually popping over to the next earthquake or hurricane staging area to offer your unique brand of assistance, and your thought was that you could just front up and start dispensing Psychological First Aid, there is bad news for you; you need to be part of an organised unit.

Psychological First Aid and the Incident Command System

One of the features of well-run disaster relief efforts is that they are so because they are organised. Disaster interventions need more than almost any other type of help-giving to be highly organised and coordinated. The Australian Red Cross field guide is unequivocal on that point. It states:

"Psychological first aid should be delivered by appropriate agencies as part of state, regional/district or local emergency management plans." (Australian Red Cross, 2010, p 14)"

Ruzek and colleagues (2007) categorically declare that the effectiveness of Psychological First Aid actions will depend partly on how the provider enters the setting. The single most important factor, they say, is that "such work should be conducted within the framework of an authorized helping organization with a structured Incident Command System." (p 24). The Psychological First Aid Field Operations Guide, currently considered the bible for those wanting to offer such support, is similarly insistent. Psychological First Aid, they say, is designed for delivery by mental health and other disaster response workers:

"…as part of an organized disaster response effort. These providers may be imbedded in a variety of response units, including first responder teams, incident command systems, primary and emergency health care, school crisis response teams, faith-based organizations, Community Emergency Response Teams (CERT), Medical Reserve Corps, the Citizens Corps, and other disaster relief organizations" (Brymer et al, 2006).

What is an Incident Command System (ICS)?

ICS is a standardised on-scene incident management system designed specifically to allow disaster responders to adopt an organisational structure that will be up to the demands of even complex incidents – single or multiple – without hindrance from local laws and regulations (Occupational Safety and Health Administration, United States Department of Labour, undated). Used for the command, control, and coordination of emergency response, it is based on a flexible response framework within which people can work together effectively. The people may come from a range of agencies that do not normally work together, and ICS is designed to give standard response and operation procedures to reduce the problems and potential for miscommunication on such incidents. ICS is a "first on scene" structure, where the first person on the scene is in charge of the scene until:

- The incident is resolved
- A more qualified responder arrives on scene and receives command or
- The Incident Commander appoints another individual Incident Commander (Wikipedia, 2012).

Why be part of an organised command system?

After Hurricane Katrina in New Orleans, a number of mental health professionals who volunteered their time for a two-week deployment published their experiences. One, Simon Rosser, was a psychologist from the University of Minnesota's Medical Reserve Corps. As a recognised team, the Minnesotan MRC was easily slotted into the Incident Command System operating in New Orleans. Thus Rosser offered the advice to:

"Go as part of a team and know its mission. Some psychologists I met had come to help, only to find themselves hampered by either lack of documentation, lack of planning, and [sic] structural challenges that left them unable to do anything. Others reported frustration working for organizations that allowed them to provide only basic supportive counseling. I strongly recommend going as part of a recognized team. I felt really fortunate to have been deployed with our university's MRC [Medical Reserve Corps] as it facilitated rapid and safe deployment to provide emergency primary health care, was able to deploy further resources as needed, and provided a team approach for support." (Rosser, 2008, p 41).

An important point to note for those who are not mental health professionals but wish to join a disaster-relief team is that, even with training in Psychological First Aid, you would want to have ongoing support, including ongoing access to expert mental health consultation and supervision. Not all psychological first aiders – even with training – will have the same capacity to carry out various interventions. For example, if you are a lay person to the field of mental health, how comfortable would you be to console and support an acutely distressed, traumatically bereaved survivor? Thus, the referral networks and "backup" consultations (with more experienced professionals on the team) are crucial to ensure quality and continuity of care, and also to minimise the risk of doing something that would harm someone you are trying to help (Ruzek et al, 2007).

History and overview of Incident Command Systems

Incident Command Systems were born after the series of catastrophic wildfires California experienced in the 1970s; many people died and property damage ran into the millions. When the massive wildfire suppression efforts were analysed, experts realised that the devastation was as severe as it was, not because of a lack of resources thrown at it or because the particular tactics attempted were "wrong", but because there were deficiencies in communication and management related to the containment response (Wikipedia, 2012). Thus, Incident Command Systems, which by 2003 went national in the United States, were developed to address the following problems:

- Too many people reporting to one supervisor
- Different emergency response organisational structures
- Lack of reliable incident information
- Inadequate and incompatible communications
- Lack of structure for coordinated planning among agencies
- Unclear lines of authority
- Terminology differences among agencies, and unclear or unspecified incident objectives (Occupational Safety and Health Administration, United States Department of Labour, undated).

ICS is interdisciplinary and organisationally flexible in order to meet the following challenges:

- It meets the needs of a community to cope with incidents of any kind or complexity – so it can expand or contract as needed
- It allows personnel from a wide variety of agencies to meld rapidly into a common management structure with common terminology
- It provides logistical and administrative support to operational staff
- It is cost effective by avoiding duplication of efforts, and continuing overhead
- It provides a unified, centrally authorised emergency organisation (Wikipedia, 2012).

The best news of all for you, if you are thinking of providing Psychological First Aid, is that – with proper planning and authorisation – there can be room for you in the structure, thus maximising your chances to have a safe and effective deployment.

Where do you stand?

What do you understand about Incident Command Systems, specifically, or emergency response administration structures generally? Chapter Six contains a list of Australian organisations involved in offering aspects of Psychological First Aid. If you are taking this course from a country other than Australia, your country may have differently-named organisations with similar functions. If you are genuinely keen to understand how Psychological First Aid is delivered, ring an appropriate organisation (for those in many countries, you could start with the Red Cross), and ask them how they structure an Incident Command System post-disaster (the answers may vary according to the needs arising in each particular situation). Try to discern where you would fit into that structure. How does knowing about this concept of Incident Command System affect your desire to offer Psychological First Aid?

Where is Psychological First Aid offered?

Psychological First Aid can be found wherever it is safe to offer it. Being a community-based approach, it often occurs in community settings near the scene(s) of the emergency or disaster. The various types of sites where it is delivered will be found wherever distressed people gather and are being served. Let's look at a few of those; some of the terms may be unfamiliar, so we explain what type of assistance is offered at them:

- Homes
- Schools
- Businesses
- Shopping centres
- Airports and train stations
- Sites of memorial services
- Community centres

All of the above sites may be converted into many of the types of centres described below, as needed by the community during a given disaster or emergency.

Evacuation centres or General population shelters – often schools or community facilities – are used to temporarily house many individuals from a community when they need to be evacuated from their homes due to dangerous or threatening conditions (such as people in the direct path of a volcanic lava flow or hurricane). Such shelters usually have room for people to sleep and an area where meals are served. The harmonious operation of these is partially dependent on how well the organisers are able to set up rules for communal living – such as what time is "lights out", or when certain groups should use the showers when water is in short supply, manage public health issues (such as sanitation), and also mediate conflicts between the shelter residents, or between residents and staff.

Service centres may be opened by governmental agencies or disaster relief organisations to meet the initial needs of disaster survivors. These might offer help in locating temporary housing or in providing supplies such as food, clothing, and clean-up materials. Obviously, the challenge for communities when there are mass displacements and disruptions is to have enough options for temporary housing and supplies for everyone who needs them; otherwise, tempers flare.

Community outreach teams are a mobile version of a general population or service centre. They are established when a disaster has affected a large geographical area or a high percentage of the population. To provide more comprehensive assistance to isolated communities, volunteers with contrasting skills might be sent out together, such as a mental health worker or spiritual care volunteer along with, say, a Red Cross worker, who would distribute food and other supplies.

Family reception centres are commonly opened right after a disaster involving mass casualties or fatalities. At these times, individuals may be trying to locate family or other loved ones specifically involved in the disaster or separated during the evacuation process. Family reception centres are often temporary holding sites until a more operational Family Assistance Center can be opened. They may be established close to the immediate disaster scene where individuals arrive in search of family and other loved ones involved in the incident, or in healthcare facilities where the injured have been transported.

Family assistance centres are commonly opened in the event of a disaster involving widespread casualties or deaths. These usually offer a range of services: mental health services, spiritual care, and crime victims' services, as well as the services of law enforcement, the medical examiner, disaster relief agencies, and other agencies may be offered on site. Family Assistance Centres are usually located away from the immediate disaster site. Family members may request visits to the affected site or memorial services. Therefore, the Family Assistance Centres should be close enough to facilitate those activities.

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

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

Hospitals and hospital emergency room settings are where survivors triaged on site and listed as "immediate" will be brought to during a mass casualty event. Also, many others will get themselves to the Emergency Room, creating a surge on medical resource capacity. Survivors may arrive in large numbers, many with both psychological and physical reactions. Medical personnel try to help treat the more seriously injured survivors quickly by removing those who do not require immediate care, but with some disasters (such as chemical or biological attack), symptoms may be non-specific and changing rapidly. Many people may arrive for treatment who simply fear that they have been exposed; systems can get quickly overwhelmed. Along with a system of triage, hospitals may set up a "support centre" where Psychological First Aid providers can refer those in need to a range of medical, psychological, behavioural, and drug interventions.

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

Recovery or Respite Centres are locations where first responders can rest and obtain food, clothing, and other basic support services. They are usually opened where prolonged rescue and recovery efforts are necessary, such as in the wake of the Christchurch, New Zealand earthquake. Respite centres are usually located in close proximity to the direct impact of a disaster. Often, those offering Psychological First Aid have limited time to interact with responders who are extremely busy and tired, and feel the need to keep working.

(Australian Red Cross and Australian Psychological Society, 2010; Brymer et al, 2006)

Common stages of disaster recovery

We refer numerous times in this course to the unpredictable and chaotic nature of disasters and mass disruptive events. Even though that is a valid characterisation of catastrophe, disaster experts have discerned a general pattern or cycle of phases that a community and the individuals in it go through from the time of impact of a disaster to establishing a newly reconstructed life. It is useful to know the general phases in order to better comprehend the situation that may exist upon entering the disaster scene. Disaster responders and relief personnel of all sorts may encounter very different situations and get very different reactions from the disaster-stricken community, depending on what phase the recovery effort is at. A general four-stage cycle has been identified. We look at the prevalent emotions, commonly-found behaviours, and the resources which tend to be most important during each phase.

Phase 1, Heroic

Occurring at the time of impact of the disaster and in its immediate aftermath, the Heroic phase is characterised by a shell-shocked community with emergency needs for food, water, and shelter.

Emotions

Grief and loss are strong at this stage, but so too are emotions of altruism. There is a sense of the heroic, of people responding from the highest, most sublime part of themselves to help fellow human beings by rescuing, offering needed supplies, and generally giving the best of themselves to meet dire needs. The firemen who went up into the stricken Twin Towers after the 9/11 attacks in New York, thereby endangering and sometimes losing their own lives, are a good example of this.

Behaviours

The community sees many heroic actions, and much energy goes into saving others' lives and property, even sometimes before one's own is looked after. An example of this occurred after both Hurricane Katrina (2005) and also the New Zealand earthquakes of 2010 and 2011, when first responders, such as the Search and Rescue teams, toiled long hours to rescue and assist survivors even though their own homes had been demolished in the disasters.

Important resources

The family groups, neighbours and emergency teams on the scene immediately are the most important source of help in the first post-disaster hours.

Phase 2, Honeymoon

From a few days after the disaster to about three to six months onward (depending on the disaster), a community tends to be in the honeymoon phase.

Emotions

Survivors – and their loved ones – feel relief at survival, and often there is still an emotional "high" of "I survived. That is what matters. The rest we can deal with." There is a strong sense in the community of having shared a terrible experience and lived through it. Public officials are often praised for their role in saving lives and organising relief efforts. For agencies such as the Red Cross, there is an excellent opportunity for fundraising. This is because people open their wallets with relative generosity as a result of feeling moved by the intense media coverage of widespread suffering and touching tales of rescue and survival. Survivors experience high expectations about the help that they will get from official and governmental agencies towards rebuilding their lives: partly because many promises are made to them at this stage.

Behaviours

It is easier to recruit volunteers during the Honeymoon phase than later on, as those giving want to know how to give help as well as material goods or money. The communications task of agencies is to help manage the expectations of all parties: survivors, the community, and general public, about what assistance the agencies themselves will be able to give. Communications must also help volunteers learn how to give help: what is needed, where, and how to deliver it. At this stage, survivors – with the help of volunteers, usually – clear out debris and await the promised help.

Important resources

Community groups which existed before the disaster (and were not wiped out by the disaster) are crucial at this stage, as well as new groups which emerge to meet specific needs developing directly from the disaster.

Phase 3, Disillusionment

Inevitably, reality sets in. Governments put conditions on the assistance they will give, insurance companies find reasons not to pay out on survivors' once greatest asset – their home – and the media and some helping agencies go home. This phase can last from several months to up to two years.

Emotions

No longer the focus of the world's (or even the region's) attention, survivors begin to experience a strong sense of anger, resentment, bitterness, and deep disappointment if they now begin to experience delays, failures, and/or unfulfilled hopes or promises of aid. People are exhausted by now, worn by the extreme stress of ongoing recovery effort.

Behaviours

At this stage, survivors question aid and governmental agencies' promises, intentions, service delivery, and achievements. The grim reality of just how long and difficult a road it will be back to "normal" presents itself. People concentrate on rebuilding their own individual lives and solving individual problems. The feeling of "shared community" is lost. Both community leaders and aid agencies have a role here in disseminating correct information, and trying to do damage control with misinformation that spreads via the rumour machine (and these days, on social networking sites as well).

Important resources

Many of the outside agencies that were active at previous phases now pull out. Local agencies may be shown to be quite weak without the outside aid, and alternative sources of funding and assistance need to be explored by the community – and possibly by individual families as well.

Phase 4, Reconstruction

Lasting for several years following the disaster, this is the long-term phase of disaster recovery. It may proceed at a glacial pace and is probably not supremely interesting to the media (until anniversary days of the event, when follow-up media reports are prepared).

Emotions

The emotions that appear here can vary widely according to (1) the status (emotional and financial) of survivors, (2) the manner in which previous stages were handled, and (3) the actual level of resources that have come available: more resources equals less survivor stress, and the converse is also true. Survivors realise that they are ultimately responsible for solving the problems of their lives. If recovery efforts are visible, the community – and through that the individuals in it – achieve a sense of efficacy, that sense of being empowered that fuels further recovery. If community efforts towards recovery are not visible, individuals are more at risk for succumbing to PTSD and other serious mental and physical un-wellness.

Behaviours

Mostly, the behaviours seen at the Reconstruction phase are those of self-responsibility. In the best case scenario, individuals and families have assumed control of their own recovery, and new construction plans reaffirm belief in their capabilities and capacity to recover. If things have been mishandled all along, and/or there are few resources available for re-construction, behaviours will tend to be more dysfunctional: the apathy of depression may be seen instead of focused movement towards re-establishment of "normal".

Important resources

At the last phase of recovery here, the people of the community and the groups who have a long-term investment in it are the crucial components. (Hallock, D., 2010; North Carolina Cooperative Extension Service, 1999)

Linking in with the community

If you were to be sent to a community that had experienced a disaster, say, three months prior to your arrival, there is some question – according to the "theory" of disaster recovery phases, above – as to which phase of disaster recovery the community might be at, yet it would be important information for you to have during your deployment. How might you figure out what the prevailing mood of the community is, and what phase it seemed to be in? What criteria would you use to determine this? How might you test your hypothesis?

Barriers and solutions

While the description of Psychological First Aid makes it sound formidable, extensive, and relatively robust – and it often is – it is well to also remember that it is a new and developing discipline. There are still a number of common roadblocks to its effective delivery. Alerting you to these potential pitfalls might mean that you are able to prevent them from having an impact on your helping efforts, or at least, you can lessen their impact.

The field setting is drastically different from the office setting

This potential stumbling block to good Psychological First Aid probably applies to you only if you are coming into the field as a professional mental health helper, for in this case you have a standard of comparison and prior expectations about what "good" mental health helping (probably counselling or therapy) looks like. And therein lies the problem. Your professional consulting rooms were organised; your sessions were structured. People came to see you at an appointed hour, and there was continuity of sessions. A Psychological First Aid setting after an emergency or disaster is hugely chaotic and unpredictable, and any structure in the situation is not only different from what you are used to, but changing, possibly radically, as the situation develops.

There is consensus that, because the setting is so different from the typical therapist's office, providers of Psychological First Aid should be pre-selected and pre-trained, including training by participation in large-scale disaster exercises (Weisaeth et al, 2007).

What you can do

Whether you are a professional mental health helper or lay person who just wants to help out, you can assess your own readiness to enter such a difficult environment (see Chapter Five), and you can prepare ahead of any critical incident or emergency by getting trained up now (this course is part of that), including practical large-scale exercises. The list at the end of this course will help you find organisations in your area who conduct such exercises.

There is a lack of infrastructure in the community near the field setting

Many volunteers have come away from a disaster deployment disillusioned, because so many of the needs they uncovered and the particular people whom they tried to assist, could not be followed up due to deficits in the infrastructure of the community they were serving. In some cases, communities (such as many of the Indonesian communities affected by the tsunami of 2004) may not have had extensive infrastructure for health, medical, and social services even before the disaster. But even for those who lived in communities with extensive infrastructure, what had been there might well have been wiped out in the disaster. One group of mental health volunteers, reflecting on their deployment in the aftermath of Hurricane Katrina in the New Orleans area of Louisiana, in the United States, wrote:

"One of the biggest challenges to our work was that systems of mental health care and social services in the Gulf Coast region had been obliterated. Also unavailable were housing, transportation, sanitation, and good communication about the changing services that were available. Although medical professionals made heroic efforts to provide care during and after the hurricane (Frank, 2005), medical care was essentially non-existent for all but immediately life-threatening situations (see Rosenbaum, 2006). Thus, we learned to live with discouragement stemming from our inability to make referrals to needed services for so many clients with serious needs" (Haskett et al, 2008).

What you can do

Although it isn't easy and you may not have more than 24 – 48 hours between volunteering and departing for the disaster scene, some volunteers recommend – where possible – reading what literature is available or finding out through other means, about what you will encounter in the community: what agencies are (were?) there, how the delivery of social services works in the area, and any tips on assessing and addressing the area's mental health (Rosser, 2008).

Lack of coordination in the setting

Words like "disaster", "catastrophe", and "emergency" have strong connotations of chaos, so to help survivors and those affected in the aftermath of a critical incident is to bring greater order and normalcy to an abnormal situation. Part of how disaster relief workers do that is by forming strong organisational structures—the Incident Command Systems described above – with clear lines of reporting and command, and as well delineated roles as possible. Not just personnel, but supplies and donated goods must be coordinated: that is, organised, inventoried, and given back out to those most in need in a controlled manner. Disaster relief annals are full of stories of good intentions gone awry due to lack of planning, organisation, or coordination on the scene. One volunteer noted that both the local and international response of wanting to assist Boxing Day (2004) tsunami-affected people was:

"...enormous – indeed, too enormous. In the UK, the Sri Lankan High Commission was engulfed with boxes of warm clothes, cooking utensils, medicines (many out of date) and so on. It was to cost a small fortune to airfreight these well-intentioned gifts, whereas had the money been donated, the goods could have been bought locally. Most of the commercial infrastructure remained intact, although this was rarely shown on television documentaries. Had the money entered the local economy, much more good would have been achieved more quickly. As it was, the sight of abandoned clothing at cross-roads became a familiar sight for a while". (Yule, 2006, pp 262 – 263)

What you can do

Most importantly, you can (must!) organise your deployment(s) as part of a team or Incident Command Structure. You can ensure that you have clear reporting lines, and that your role is clear from the outset, even though it may be highly variable and hugely different from your normal role(s). You can seek collaboration and co-ordination with colleagues wherever possible.

Lack of cultural sensitivity

Of the numerous reports by mental health volunteers included as part of this course (See Chapter Five), nearly all reported that, from their personal experience, trying to do Psychological First Aid without any cultural sensitivity would have been futile: the disaster relief equivalent of trying to fly an airplane with no wings or propeller. Some noted that having personal or formal knowledge of the social, cultural and political experiences of culturally diverse groups where they were volunteering helped to establish rapport, trust, and credibility as professional helpers with their clients (Haskett et al, 2008).

Trauma work can bring a provider of Psychological First Aid into any town, any region, or any country. Working with people and families who represent a range of ethnic, racial, socioeconomic, and religious diversity is the norm, and team members must therefore be readily able and effective in their efforts to engage and collaborate with local communities (Everly & Mitchell, 2003). Cultural competence has been noted as important by people who have provided disaster mental health services in ethnically diverse regions (Dudley-Grant, Mendez, & Zinn, 2000), and guidelines for provision of such services to ethnic-minority individuals are provided in the literature (Norris & Alegria, 2006).

The cultural sensitivity of the provider can help, hinder, or jeopardise the therapeutic relationship. Rosser, a psychologist from the northern state of Minnesota volunteering in the wake of Hurricane Katrina, noted that one of the first things his team needed to do was begin observing Southern norms for politeness and formality. So instead of being Dr Rosser, he was "Doc Simon", along with "Nurse Betty", and "Mister Joe". Equally, the Minnesota team needed to refer to their clients as "Miss Carol" (not "Carol") or "Mister Donald". They took the position that they were guests in that region of the country, and therefore needed to learn their norms and rules for behaviour (Rosser, 2008).

Another team serving in the same disaster noted the negative impact on a Black-American client from the area when a staff member asked, "If these are all your children, why do they each have different last names?" Of course there are many possible answers to this question. However, the cultural expectation of the staff person was that all children within the same family should have the same last name, a situation that commonly does not obtain in the southern part of the United States, and which probably put at risk the development of rapport with that client (Haskett et al, 2008).

If disaster mental health and other teams were to move into communities and dispense "off the shelf" services to passive "patients" and families from a top-down service-delivery position, they would be creating a huge barrier to effective delivery of Psychological First Aid.

What you can do

Your mission before entering the disaster setting, should you choose to accept it, is to find out all you can about the culture(s) that you will be interacting with, and what their expectations of the volunteers are. Specifically, you will want to find out the cultural taboos the violation of which would see you branded as culturally incompetent, and jeopardise your relationships with those you are trying to help. Even observing small things (small to you), may be very important to the host culture. In the Maori culture of New Zealand, for example, it is the height of rudeness to sit on a table. In Palau, Micronesia, one must try to avoid passing between two people talking. If that is not possible, one must crouch as far down as possible while passing, and one must never be in a higher position than the chief (difficult because they tend to sit on the floor).

Compassion fatigue

No discussion of potential barriers to the delivery of Psychological First Aid would be complete without mentioning the ever-present potential for "melt down" or burnout. In the highly-charged, high-pressure atmosphere in the aftermath of a mass catastrophe, personal resources – physical, emotional, and spiritual – are depleted quickly. It is an extremely important issue to attend to, because the gruelling nature of work in a disaster setting poses extra risks for acquiring mental health problems.

From chronic exhaustion to sickness, irritability and overwhelm, the symptoms of compassion fatigue are many. See Chapter Five for a more complete discussion of how this may manifest in a field setting. Suffice it to say here that, when those coming to lend psychosocial support to others need extra mental health support themselves, it poses a considerable challenge to a team's effectiveness in the field, diminishing greatly the resources actually available for helping.

What you can do

We take up the question of doing appropriate self-care and working through personal issues in Chapter 6. Note that even if you are working long hours in a highly disturbing and chaotic setting, it is possible to engage in self-care. This must be also viewed as care for the distressed community members you are seeking to serve, because providing a calm and emotionally intact presence is one of the most significant gifts you can give a survivor of a traumatic incident, and it is a mainstay of Psychological First Aid.

Issues of flexibility and scope of practice

Trauma teams are multi-disciplinary by their very nature, as they include providers who represent a range of medical and mental health disciplines. Teams will often have a number of lay members (such as teachers, pastors, and school administrators) as well, whose "normal" professions are other than medicine or therapy. Although each person brings a unique set of understandings, wisdom, and lived experience, the whole team, in order to be effective, needs to be trained in common understandings about individual and group interventions related to crisis management.

The problems of scope of practice versus flexibility come into play when, not only the professionals, but the lay team members as well, question just what they should be allowed to include in their scope of practice, and what they should definitely exclude. The heightened energies of the crisis situation and the often concomitant scarcity of appropriate personnel mean that the most successful team is a flexible one. Some psychologists reported that, during their two-week disaster deployments, they – competent in advanced level therapies – have most appropriately taken up jobs of serving food, accompanying mobile vans in an outreach effort, sweeping floors, and other humble tasks, while other team members have equally stepped outside their ken, in the interest of serving demoralised communities. Mendenhall eloquently frames the issue for Psychological First Aid when he asks:

"Should a physician provide mental health interventions if there is another member on the team whose primary professional identity is that of a therapist? Can a psychologist assist in the drawing up of medications or vaccinations? Is it okay for a community member who normally works as a high school teacher to facilitate a group intervention for families whose loved ones are missing? Can a marriage and family therapist assist in cleaning a wound? Can a nurse help a young girl look for her father through pictures of tsunami victims buried in mass graves, or cry with her when she finds the picture and ultimately confirms that her father is dead?" (Mendenhall, 2006)

Ultimately, each psychological first aider needs to find where to draw the lines between flexibility offered in the name of helpfulness and recognition that, even in a crisis situation, there are some interventions that should not be undertaken. These may be so far outside a reasonable "scope of practice" that, to do them would cause harm.

What you can do

This issue represents more of a challenge to effective Psychological First Aid than it does a barrier. As such, each person responding to the call for help can undertake to gain as clear a job description as possible, and go in with the advice of one volunteer's mentors: "Expect the unexpected." (Rosser, 2008).

Summary

This chapter has fleshed out our skeleton understanding of Psychological First Aid. The risk and resilience factors that are known to kick in after exposure to adversity, the trauma responses in a survivor that would indicate Psychological First Aid is needed, and the who and where of service delivery are all key components to understand. If you deploy to a field setting, you will undoubtedly need to understand the Incident Command System within which you will work, so this concept has been imperative to include for you. Similarly, it is helpful to your field deployment to know about the phases of disaster recovery (to discern how far the community has moved) and the barriers to effective Psychological First Aid, because you can overcome the impact of many of them. Chapter Four gets down to brass tacks, examining the core principles and actions of Psychological First Aid.

Linking in with your possibilities

Review the list of possible barriers to effective Psychological First Aid, and see which, if any, you might be able to work through before you deploy to a field assignment. For instance, consider these questions:

1. Where (with which organisation) might you be able to complete a practical field training exercise?
2. Do you have a sense of which region you might like to deploy to? You might be able to do some advance research on health and other services there (that is, the community infrastructure), or alternatively, read about the cultural practices of the area.
3. How is your self-care? Are your routines well-established enough that you would probably be able to carry most of them on even during an intensely demanding stint in a disaster setting? You can read more about this in Section Six.

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Chapter 4

The Core Principles of Psychological First Aid

The next two chapters are about coming to grips with the main principles and actions that in recent years have come to be known as Psychological First Aid. What are those guiding principles? And what are the consequent actions that should follow on from them?

To help us understand the challenges faced by this still-developing discipline, let us posit for a moment that you are the premier of a beautiful state called Joyland. Blessed with a comfortable climate, abundant resources, and a good location, Joyland has enjoyed many years of peace and prosperity. Most of the state's long-term residents have never experienced a natural disaster. All of that changes one day when a ferocious cyclone rips through, causing widespread devastation to property, crops, and – mostly – the sense of safety and security of the inhabitants.

As premier, you spring into action immediately, making sure that residents are rescued and brought to shelters, where they are given blankets, food, and water. But even though the total number of deaths from the cyclone is low, it becomes clear early on that many of the people are showing signs of severe trauma reaction, and you and your closest advisors are uncertain how to proceed. That is, you face the $64,000 question: what do the affected residents – indeed, the whole community – need, both in order to get by right now, and also to ensure a less traumatised, more mentally healthy future?

You are not alone in asking that question. To understand the basic principles of what should happen for a community such as this, we will be working with a strong focus on the work of Hobfoll and his associates. In attempting to understand what survivors need, they have laid out five overarching principles that valid and effective Psychological First Aid must follow. But first, here are the objectives for this chapter.

Objectives

By the successful completion of this chapter, you will be able to:

1. Name five aspects of promoting safety
2. List at least six trauma-induced stress conditions arising when the protective shield is either broken or under threat
3. Discuss how heightened emotion and numbing can be both adaptive and maladaptive in the aftermath of a disaster
4. Identify at least five techniques to promote calming
5. Explain the consequences for disaster survivors' sense of efficacy of a break in the belief-behaviour-resources chain
6. Describe how promoting connectedness among survivors may both help and hinder recovery efforts
7. Given the controversy around definitions of hope, name three interventions to promote hope that are considered safe for individuals and communities.

Hobfoll's PFA principles: distilling the five essential elements

Noting the powerful negative impact of disasters and mass violence on communities, Hobfoll asserted that any policy for helpful intervention after a disaster or terrorist event needed to be based on the most updated research findings (Hobfoll et al, 2007). The problem, however, is that "no evidence-based consensus has been reached to date with regard to effective interventions for use in the immediate and the mid-term post mass trauma phases" (Gersons & Olff, 2005). There is no disagreement that people immediately need to have their basic needs met: for food, water, and shelter. But what about their psychological and social needs? A large proportion of the research that has looked into the question of mental health care in the aftermath of a disaster has focused on interventions like Critical Incident Stress Debriefing, where disaster-affected people are strongly encouraged to talk early on about the event. As we have previously noted, the studies have generally shown that this doesn't work (Litz et al., 2002; Bisson, 2003; McNally, Bryant, & Ehlers, 2003; Watson et al., 2003). But what approach might be effective?

The gap in the field has led to a search for an "evidence-informed framework" (Hobfoll et al, 2007, p 221) for post-disaster psychosocial intervention. Because there has been no direct evidence, Hobfoll and his colleagues (all experts in the field of mental health or disaster response) extrapolated from related fields of research to try to:

1. Create evidence-informed practices
2. Gain consensus from researchers and practitioners in the fields of trauma and disaster recovery about what is workable
3. Identify core intervention-related principles that are best supported in the literature as promoting resilience following exposure to extreme stress.

Hobfoll acknowledged that, because traumatic events are so different from one another, it would be necessary to retain flexibility; any guidelines would need to be adaptable to specific circumstances. Thus, rather than propose specific interventions, he and his associates addressed the issue by laying out several general principles for successful intervention, formulating them in a way that would allow smooth translation to specific circumstances.

What follows (cited by most authors writing about Psychological First Aid) gives their "best intervention practices following major disaster and terrorist attacks for the short-term and mid-term period" (p 221). They defined that period as ranging from the immediate hours to several months after disaster or attack. The best intervention practices are the five principles that we have been naming so far throughout this course: the promotion of safety, calmness, self-efficacy, connectedness, and hope. Let us see what is involved in each of them.

Promoting a sense of safety

It seems self-evident that a number one goal in reducing trauma is to help a survivor or a disaster-affected individual to relative safety, yet there are several angles to this issue. They involve:

1. Restoration of the protective shield
2. Reducing deeply embedded neurobiological reactions that come with fear and anxiety
3. Correcting trauma-influenced views about the "dangerousness" of the world
4. Dealing with safety in the social system, including safety from rumours and unbalanced information
5. Dealing with safety challenges due to media presentation.

Restoration of the protective shield

Writers on the question of promoting safety are clear that there are two aspects to be dealt with: objective reality (that is, actually being safe from threat or harm) and perceived reality (that is, a person's sense that they are out of danger). It is the nature of catastrophes and mass violence that they force people to respond to events that threaten their lives, their loved ones, and the things that they most value. For both children and also caretaker adults, such events threaten to disrupt the "protective shield" that gives stability to family life and underlies much of a young person's healthy early development (Pynoos, Steinberg, & Wraith, 1995). Not only children, but people across the spectrum of ages develop stress reactions when the "shield" is threatened or broken. Mental health problems from this source include:

- Acute Stress Disorder
- PTSD (Post-traumatic stress disorder)
- Depression
- Anxiety
- Separation anxiety
- Incident-specific fears
- Phobias
- Somatisation (when survivors manifest trauma in physical conditions)
- Traumatic grief
- Sleep disturbances (Balaban et al, 2005)

Studies have shown that these conditions tend to persist when there is ongoing threat or danger (de Jong et al, 2001), but reduce over time when individuals are brought back to a situation of safety (Ozor, Best, Lipsey, & Weiss, 2003). It has also been shown that people who can re-establish a relative sense of safety, even when the danger or threat continues, have a lower risk of developing PTSD in the ensuing months than those who do not maintain such a sense of safety (Bleich, Gelkopf, & Solomon, 2003).

Reducing deeply embedded neurobiological reactions that come with fear and anxiety

When people are faced with catastrophic events such as disasters and mass violence, they respond with neurobiological and psycho-physiological reactions that are connected with the "flight or fright" response. Hard-wired into our brains as human beings, these reactions originally helped survival by setting up chemical and physical responses in the body that alerted early human beings to danger, and helped them to fight it or run away. Such responses are deeply embedded in the brain, and as such are a biological response, not easily amenable to change by "positive thinking" or other psychological approaches. Research has found that promoting a sense of safety is essential in both animals and humans to reduce these responses that manifest with fear and anxiety. Researchers believe, by implication, that promoting safety can reduce the biological aspects of PTSD (Bryant, 2006).

Correcting trauma-influenced views about the "dangerousness" of the world

There are some aspects of safety which can be enhanced by working with survivors' minds, however. There is a high correlation between recovering naturally from exposure to trauma (without mental health interventions) and having a balanced view about how dangerous the world is. And the converse is also true: holding a belief that the world is extremely dangerous has been identified as one of the main thought patterns which tends to increase the risk of developing PTSD (Foa & Rothbaum, 1998).

Trauma memories tend to be caught up in emotion, and can be easily triggered by a variety of reminders (usually innocent), making survivors feel like they are back in the disaster, even after safety has been restored. Thus, working with their minds to provide corrective information helps to ensure that they can evaluate future threat in a realistic manner. Similarly, people who are likely to develop mental health problems in the months following a disaster are those who exaggerate future risk (Smith & Bryant, 2000). If actual safety is not restored, reminders will be all around the person, contributing to an ongoing sense of exaggerated threat and preventing a return to having a sense of safety (Ehlers & Clark, 2000).

The way that safety can be promoted in these cases is to break the linkages survivors have made in their minds between harmless images, people, and things and dangerous stimuli associated with the original traumatic event. Then, through imagined exposure and also in-vivo (live) exposure, those harmless images, people, and things can be re-linked with safety. An example of this type of safety-promoting intervention might be the adult that says to the child, "That trip to the mall was dangerous, but not all trips to the mall are dangerous." Mental health experts have also used reality reminders, lessons in changing cognitions (thought patterns), the development of coping skills, and also grounding techniques to enhance disaster-affected individuals' sense of safety (Najavits, 2002).

Another main therapy objective, especially when working with traumatised children, is to reverse their trauma-diminished capacity for discriminating between that which is dangerous and that which is not. Obviously, if many things in the environment are triggering someone into an acutely anxious state, the person might consider that just about everything is dangerous, and fail to respond appropriately. In both combat situations and on a public health level, the more people can be removed from a dangerous situation to a relatively safe one – which they are clearly given to understand is safe - the more their biological and psychological reactions can reduce. Taking this action can help to restore confidence in the "protective shield", but it is often slow work (Pynoos et al, 2005).

Dealing with safety in the social system, including safety from rumours and unbalanced information

In the early hours and days after a disaster or other critical incident, there is often little hard information available about what has happened or is happening, especially as an event is still unfolding. Without correct information, people tend to share rumours and "horror stories", especially to those offering social support. Thus, in terms of how trauma works, everyone participating in such rumour conversations is "re-exposed" to the event, and those providing social support get a multiple dose. Studies have shown that increasing doses of this type of "support" are positively correlated with psychological distress (Hobfoll & London, 1986). Interventions to promote safety, therefore, should recommend to survivors that they limit this type of conversation if it makes them anxious or depressed (Hobfoll et al, 2007).

Clearly, we must consider "safety from bad news and rumours" as part of the total safety picture. The intervention that leaders can make is to speak with an accurate, balanced, and well-organised voice in order to increase the perception of safety where there is no actual threat occurring (Shalev & Freedman, 2005).

Finally, in the aftermath of a disaster people are commonly most worried about the fate of loved ones. These concerns often override individuals' concerns for themselves, so priority interventions must aid the identification of loved ones and their condition. Although being connected to others for social support is also important (another principle, as we will see), here the idea is find out about the fate of loved ones in order to promote safety.

Dealing with safety challenges due to media presentation

In a similar vein, there is the question of what the media do to promote or undermine a sense of safety, and particularly, how leaders use the media with respect to these issues. You may have heard the saying, "Good news is not 'good news'". A community source of fear in the aftermath of a disaster or terrorist act can include government-issued messages, delivered through the media. Even if a leader is well-intentioned and is genuinely attempting to keep the public informed, if the message is not carefully orchestrated, it is possible that it may increase anxiety and make people less clear about how to act. Sadly, not all politicians are well-intentioned, and such messages often come to be used for political gain (such as when leaders exaggerate a terrorist threat in order to be re-elected: i.e., the message, "The world is a dangerous place. Re-elect me and I'll protect you.").

As a provider of Psychological First Aid, you may believe that you have no capacity to influence at these levels, yet organisations such as the American Psychological Association in the United States and their counterparts in other countries have taken a stand on the use of the media to create fear and anxiety for political gain (such as politicians may do), or economic advantage (such as to sell more papers, which the media may do).

Linking in: fear, anxiety, and "dangerousness"

Take a few moments to reflect on the behaviour of someone you know (or perhaps knew in the past): someone who seems anxious or fearful. Recall their behaviours which give you this impression. It could be traits such as being hypervigilant or over-concerned with security, or a global inability to trust anyone, anywhere. It does not matter whether or not the person has survived a disaster; the point is, they are manifesting fear and anxiety.

Now, think about what you know of their world view: the way that they believe the world to be. How dangerous do they seem to believe that the world is? If you are uncertain, engage them in conversation about their sense of how safe – or not – the world is. What do you find? Does their world view match their behaviour; that is, do they believe that life is something one should be frightened and anxious about? What, if any, interventions would help this person to live with a greater sense of psychological safety?

Promoting calmness

Early emotion or numbing: adaptive, but for how long?

Individuals who are exposed to mass trauma or violence are likely to show a noticeable increase in emotionality in the immediate aftermath of the event. Some anxiety is normal at the early stages, and in fact, indicates that the person's system for maintaining vigilance is intact and operating in a healthy manner. Paradoxically, some individuals will go numb in the early period after a disaster or emergency. This, too, is a normal and adaptive response, as the person's psychological system is providing much-needed insulation from the terrible event (Bryant, Harvey, Guthrie, & Moulds, 2003).

The question for providers of Psychological First Aid is not whether these relatively extreme states occur, but for how long they continue. When heightened arousal or increased numbing begins to interfere with activities such as sleep, eating, hydration, decision-making, and the performance of everyday life tasks, then it is impairing, and likely to lead to incapacitating anxiety, panic attacks, dissociation, or PTSD (Bryant et al, 2003). Moreover, prolonged states of either arousal or numbing may lead to agitation, depression, and somatic problems (Shalev & Freedman, 2005). Given these findings, it is not difficult to see why Critical Incident Stress Debriefing (CISD) has been criticised when used in the very early after-stages of a trauma. The activities of CISD (for example: telling someone to ventilate) tend to increase arousal just when the survivor or disaster-affected individual needs to calm down and restore equilibrium after the event.

The other major reaction to trauma that providers of mental health support need to be alert to is that of avoidance. The problem for survivors who begin to use this response is that, once a context or situation has been perceived as threatening, neutral or ambiguous stimuli are also more likely to be interpreted as dangerous. Initially adaptive as individuals' response of fear can help warn and protect them, the reaction comes to be maladaptive, because the number and type of stimuli perceived as threatening tend to increase over time, putting increasing restrictions on the affected person's life (Hobfoll et al, 2007).

These are serious symptoms, so the Psychological First Aid principle of promoting calmness early on is an essential element of any mental health intervention.

The interventions that promote calm for individuals

Therapeutic grounding is used to remind people that they are no longer in the danger zone, and that their thoughts and feelings are not dangerous in the way that the original disaster was. This technique is important because people who begin to develop PTSD often re-experience the trauma in intrusive memories and dreams.

Breathing retraining is simple but effective at helping survivors to breathe deeply and avoid hyperventilating or dissociating (Foa & Rothbaum, 1998); it helps to counter anxiety. Deep muscle relaxation, yoga, and mindfulness meditation can teach relaxation, and help individuals calm themselves and gain control over their anxiety (Cohen Warneke, Fouladi, Rodriguez, & Chaoul-Reich, 2004).

Stress Inoculation Training (SIT) techniques are part of Cognitive Behavioural Therapy (CBT), and help people to manage anxiety and stress. Typically, survivors or disaster-affected individuals would receive education sessions and also be practically trained in coping skills, such as deep muscle relaxation, breathing control, assertiveness, thought stopping, positive thinking, and self-talk. The idea behind SIT is that, for a lot of people, trauma-related anxiety tends to generalise to many situations, so global techniques (that is, methods not specific to a particular set of circumstances) are most useful. While SIT techniques were originally designed for individuals, they have been shown to work when large groups of soldiers with combat stress are trained in them (Rothbaum, Meadows, Resick, and Foy, 2000; Solomon, 2003). Hobfoll suggests that SIT may thus be efficacious as a public health tool in the wake of a disaster with mass casualties (2007).

Normalisation plays a major role in reducing anxiety and engendering calm for people who develop more severe stress reactions. When individuals believe that they are weak, "going crazy", or have "something wrong with me", a key intervention is to normalise by reassuring them, "You are neither sick nor crazy; you are going through a crisis, and having a normal reaction to an abnormal situation." (Solomon, 2003). By giving survivors accurate information, education about reactions, and, sometimes, CBT-based approaches, their negative thinking can be challenged.

Positive emotions. Researchers in recent years have studied the link between positive emotions and coping with stress, trauma, and adversity, and find that emotions such as joy, humour, interest, contentment, and love have the capacity to lead to effective coping. Accordingly, part of promoting calm may be encouraging disaster-affected people to increase activities that foster positive emotions. By implication, such individuals should also reduce or eliminate the time spent watching, listening to, and reading information, such as news, which produces negative emotional states. Clearly, the challenge for the psychological first aider here is to convince people that they do not need to be as vigilant as they believe, and limiting media exposure to morning, afternoon, and early evening may be enough; all day long is too much (Fredrickson, 2001; Hobfoll et al, 2007).

Problem-focused coping involves giving training and structure to the skill of solving problems by breaking them down into manageable units. Hobfoll and colleagues (1991) found that following mass trauma, people often interpret the challenges of the disaster and mass violence circumstances as one massive, unsolvable problem. Getting critical guidance in learning how to divide the problem into do-able units helps to increase individuals' sense of empowerment and control, and – practically speaking – decreases the actual number of problems they need to solve. All of that tends to decrease depression and anxiety, which promotes calm and engenders hope (Baum, Cohen & Hall, 1993). Naturally, interventions like this also work to promote self-efficacy, because individuals come to be more empowered through re-discovering their problem-solving skills. We will look at that aspect shortly.

False friends: the interventions that work right away, but harm later

Drugs such as benzodiazepines have an immediate calming effect, but have been shown to increase the likelihood of medium- or longer-term PTSD in survivors who show symptoms of trauma in the early stages after a disaster (Gelpin et al, 1996). This may be because such drugs increase distress, which decreases a sense of mastery and control. Alcohol has a similar soothing capacity, and is often used by people to self-medicate, which leads to both potential misuse and also other alcohol-related behaviours. Lies and "spun" information, similarly, may be used initially to calm a group or community, but ultimately these undermine credibility and are counter-productive (Hobfoll et al, 2007).

Interventions that work large-scale

Psycho-education techniques, at the heart of some of the individual interventions suggested above, have been shown to be effective in reducing PTSD, and can also be used as part of large-scale community outreach. People in a traumatised community post-disaster can be calmed through normalising and validating their predictable reactions to the disaster. At the same time, they can be

trained in ways to tolerate and sometimes regulate severe emotional states. It is hugely calming to appreciate how normal intense emotions are following on from disasters and mass catastrophes; thus, psycho-education is a powerful intervention to help affected communities avoid pathologising their reactions. Psycho-education can be delivered effectively through media and community processes, such as churches, schools, and businesses (Hobfoll et al, 2007).

Anxiety management techniques for mass consumption: the role of the media and the internet. Along with psycho-education about reactions, disaster-affected groups and communities can be taught techniques for anxiety management which are linked to specific post-disaster reactions (for example: sleep problems, new fears related to the incident, reacting to reminding stimuli, and being easily startled). Especially in circumstances in the aftermath of a disaster where people might fear going out, or indeed be advised by authorities not to go out, they will be more reliant on television, radio, and internet communications for news and advice. The media in such cases could take on educating the community about aspects of sleep hygiene, relaxation training, and guidelines for media exposure. Of course, the goal here is to ensure that people also do not fail to recognise when there is a reaction severe enough to warrant professional mental health assessment and intervention (Hobfoll et al, 2007).

Interventions to furnish needed resources. We need to remember at all times that none of the foregoing techniques are a substitute for actually providing material and other resources for distressed survivors. For the majority of disaster-affected individuals, the most calm-promoting action of all is to directly help them solve the concerns arising from disaster-engendered losses. This is logical given that research shows that resources losses initially (and sometimes further losses later on) are the best predictors of psychological distress (Freedy, Shaw, Jarrell, & Masters, 1992). Actions to restore losses or furnish material resources for recovery are thus generally the best antidote to stress disorder.

Linking in with yourself

How calm are you? Which of the above interventions to promote calmness do you regularly engage in? Which, if any, might you be interested in adding to your normal routines? Which would you feel comfortable to recommend to anxious survivors of a disaster?

Promoting a sense of efficacy, individual and collective

Probably no construct or component of recovery has received as much attention in psychology as the importance of having a sense of control over positive outcomes. The belief in individuals that they are empowered to help themselves sort out problems is a major factor in them enacting the behaviours to do so. This sense of being empowered has two aspects:

- Self efficacy: individuals' belief that their actions are likely to lead to generally positive outcomes, mainly through regulating their thoughts, emotions, and behaviour;
- Collective efficacy: the sense that one belongs to a group that is likely to achieve positive outcomes. (Carver & Scheier, 1998; Benight, 2004).

The achievement of efficacy has some interesting twists and turns, however, so let us look at these as a way of understanding which interventions might work to promote this all-important characteristic.

Spreading incompetency

Let us say for the moment that you have just survived terrible flooding. You and your spouse clung to the roof of your home for hours, hoping someone would rescue you. No one did, but the waters began to recede just centimetres below the highest point on your rooftop – your chimney – where you clung perilously to life for hours. Climbing back down eventually: soaked, hungry, and utterly dehydrated, you slowly begin to appreciate the enormity of the task you face in rebuilding your life. Through being in shock, you and your spouse both have had reactions, but different. Your spouse began to show wild

emotionality; you went numb, as if to insulate yourself from the horrible reality of your completely ruined home. Friends, family, and even strangers applaud you for surviving, but you know that there is much more to the story than that.

In the first few days after the floods, you know that you need to re-establish how you meet your basic needs, but you both feel so traumatised, you don't even know where to turn. Where do you find a place to live, with most rentals in your small community snapped up instantly by other survivors? How will you feed yourselves, if not by standing in a queue at the shelter? And how on earth will you pay for a rental apartment and any groceries, because, of course, all the cash and debit/credit cards were swept away. Immediately, even though you count yourselves extremely fortunate to be alive, you can see that you have some major tasks ahead of you to recover even minimally.

At first, disaster relief personnel are urging you to think small: just do now what you have to do for life to carry on. OK, but at the moment, your head feels far too fuzzy to work out even which credit cards you had, let alone how to replace them. Of course, banks will demand identification, so you have to replace your driver's license as well, and in fact, you will struggle with getting your Medicare card reinstated without some of the other identification. Without being able to access any funds, you are dependent on handouts from disaster relief agencies, and you certainly won't be able to lease a place to live.

As the days go by, and slowly turn into weeks and then months, you reckon that things should be getting better, and you should feel more competent to start getting the recovery ball moving, but it's not happening that way. Instead, the opposite is taking place. Before, you had a sense that you were generally competent in life, even if your to-do list from the disaster seemed overwhelming. Now, however, you have noticed that that sense of helplessness and "can't do", originally assigned to flood-recovery efforts, has spread to other areas of your life. The other day someone was trying to give you some clothes to wear, and asked whether you wanted a red or a blue one, and you found that you couldn't even make that simple decision! When your spouse gets emotional about your losses, you have no sense of how to provide comfort, although you were good at it before. And you haven't got the vaguest idea of how to get through the paperwork to make a claim to your insurance company for the loss of your home. In fact, you almost can't remember which company you are with! In short, everything is made much more difficult, not only by the initial shock, but by the spreading sense of incompetence at solving any life tasks.

Moreover, before the floods you were proud to be part of your little community, and convinced that, all pitching in together, you could accomplish miracles. As the weeks have gone on, however, you are not so sure. Efforts to make applications for both longer-term relief and also shorter-term funding have gotten bogged down in bureaucratic red tape. Phone calls to ask how you are doing have become infrequent. Because nearly everyone is in the same boat as you, nothing seems to be moving. Many businesses (including the one your boss had) have not re-opened, so unemployment has risen quickly. You don't even know where to look for work now, let alone how.

You could never have imagined how quickly you could go from a competent, organised, life-enjoying family and community member to this disempowered shell of your former self, with a vastly shrunken view of what you and others around you are able to do. In short, you have lost your sense of both individual and collective efficacy.

Given our goal to understand how efficacy can be promoted in the above very typical situation, let's ask you to swap roles. Imagine now that you are a provider of Psychological First Aid, and you have been trying to come to grips with why individuals and families like the one above have struggled so much to organise themselves post-floods. It seems so simple: you have told them over and over again that they will need to fill out this particular form in order to get some special government funding to tide them over until decisions can be made about their home. There are also forms for insurance and other matters. You have advised them on endless details, sometimes repeatedly, yet each time you meet with them, the things they promised to do at the previous meeting are still undone. As a psychological first aider, you wonder where you are failing. In truth, restoring a sense of self-efficacy is often larger than you, and larger than this couple. Here are some of the reasons why.

Self-efficacy cannot occur in a vacuum

To own a sense of self-efficacy, we need to be able to collaborate with successful partners, parties with whom we can solve the large-scale problems that are beyond the reach of any single individual, be that person a survivor, a provider of psychological first aid, or someone in an entirely different role. So, when collective efficacy breaks down through community systems failing, say, or getting caught up in administrative delays, perceived self-efficacy is also vulnerable (Benight, 2004). Collective efficacy can be promoted through activities which are conceptualised and implemented by the community itself, including religious activities, meetings, collective mourning and healing rituals, and rallies. After the Indonesian tsunami in 2004, for example, one of the major mental health interventions involved the community re-building of fishing boats, which allowed fishermen to resume their daily activities. Similarly, the World Health Organisation recognises the re-building of schools as a move towards collective efficacy for children and adolescents, who can then achieve individual efficacy through renewed learning opportunities (Saltzman et al, 2006).

The family must be strengthened to build efficacy in the community

When there are psychological, material, or social losses, they are felt most keenly at the level of the family, as members grieve for the dear ones and possessions that have been lost. Families are an important source of social capital (Murthy, 1998), and are often the main provider of mental health care after a disaster, especially in rural areas. Often the family is a substitute for professional care, so it should be regarded as an important axis for Psychological First Aid interventions. Competent communities provide safety, make material resources available for rebuilding and restoring order and security, and help instil hope for the future. Through these efforts, communities promote perceptions of self-efficacy among their members, they engender a sense of others being available for support, and they support the families that then support their members. When individuals perceive that they are being supported, they are emboldened to take actions that would otherwise seem too difficult or risky. Thus the rooftop-clinging couple of our example would be exactly the right place for psychological first aiders to focus their helping efforts. There is more, however, that we need to know if we would understand about efficacy, and what can help to promote it.

Self- and collective efficacy require the knowing of certain behaviours and skills

We can act with greater efficacy if we have perceived efficacy: that is, if we believe that we can solve our problems. But a belief in our capacity for solving our problems does not sustain us for long if it is not based on actually knowing certain behaviours and skills. Not reinforced by successful action, our beliefs would crumple, quickly compromised (Bandura, 1997). Unsurprisingly, studies show that maintaining a belief of efficacy is best developed through a series of practice situations which are increasingly difficult and which, through incremental successes, build to a reality-based sense of efficacy (Keinan et al, 1990).

Empowerment without resources is counterproductive

We can have total belief in ourselves, and be highly capable of backing that up with appropriate action, but if there are no resources for us to act on, we feel demoralised, and our recovery is even slower. Research on disasters and trauma has shown over and over again that those who lose the most personal, social, and economic resources are the most devastated by mass trauma (Galea et al, 2002). Studies also tell us that those who are able to sustain their resources have the best ability to recover (Benight, 2004). As noted earlier when we spoke of the Conservation of Resources Theory, self- and collective efficacy are themselves personal resources which are likely to diminish post-trauma (Freedy et al, 1994). We can make the most of them if we use them – these ways of experiencing empowerment – to organise, manage, and generally orchestrate other resources.

Psychological First Aid interventions fail when the link between belief, behaviour, and resources is not understood

So putting all these points together, let us return to the couple on the roof: the one we asked you to imagine you were part of. As part of this survivor-couple, you probably had some belief in yourselves (or at least one of you did, to encourage you both to hang on to that chimney for hours on end). You may have been challenged to enact recovery-oriented behaviours because of the shock and grief of your losses (including the loss of your sense of self-efficacy). These are reactions that, sadly, tend to widen

to more areas of life as time goes on, especially without mental health intervention. But – and here is the most formidable challenge for those providing Psychological First Aid – even if you were to get over your shock and loss of empowerment arising from the disaster, recovery will stall if there are not adequate resources for you to use.

Because of the situation of no resources – for instance, in the flood case we have posed: no rental properties available in the community – it would be easy for you to believe that you had failed, when in fact the circumstances failed you. Similarly, it would be easy for those providing mental health interventions such as Psychological First Aid to make interventions that didn't work: for instance, providing you with a list of rental agencies to call, when in fact, those might already be swamped with applications that they cannot fill for housing. Similarly, a psychological first aider might suggest to you as survivor that you take certain steps to secure a new job. If there are no longer genuine vacancies in a community which has had many businesses obliterated in a disaster, those steps are only likely to cause confusion and discouragement; they will not enhance efficacy.

Beyond the flood example we have posed, there are always questions of unequal distribution of resources in society: a situation occurring well before any disaster takes place. Factors such as poverty, being a member of a marginalised group, or having resources already depleted (such as in the case of prior experience with disaster or possibly psychiatric or health history) will always influence how well different groups access a belief in their ability to achieve positive outcomes, which influences their behaviour in trying to achieve them, which influences and is influenced by the availability of resources. Breaks in the linkages of these three crucial elements will always present challenges for those who would intervene to promote efficacy in disaster-affected individuals and communities.

Linking in with not coping

Think of a time when you or someone you know is/was facing adversity: someone who has had losses, and does not seem to be coping so well.

If they do not seem to be functioning with self-efficacy, it's possible that their "belief-behaviour-resources" chain has broken down. From your observation, at which link is the chain broken:

- Belief: they are no longer able to hold the view that they are empowered enough to do what they need to do to rebuild their lives after the hard times; they feel hopeless, and perhaps helpless.
- Behaviour: they are acting in ways that show a lack of self-efficacy, such as by not doing needed tasks to rebuild their lives, or by acting illogically or in self-defeating ways
- Resources: they still believe in themselves and their ability to prevail over the adversity, and they are acting or would act with empowerment, but the situation in which they find themselves is devoid of sufficient resources to sustain empowered action.

What could happen for this person to help restore their belief-behaviour-resources chain?

The combination of unequal distribution of resources and the fact that most of us don't get practice at responding to disasters (unless we work on a disaster relief team) means that there will almost always be holes in how this belief-behaviour-resources link works, whether at individual, family, group, or community level. Thus, the best interventions to promote self- and collective efficacy may be those that combine Psychological First Aid and other mental health interventions with development initiatives (de Jong, 2002). Understandably, if you are a new provider of Psychological First Aid hoping to make a significant individual impact on the next disaster relief program, this could be disappointing news, as it is larger than a single person's efforts. Let us turn now to the fourth element, connectedness.

Promoting connectedness

An internet search of "social support" yields thousands of articles on the importance of social support for people in distress (Australian Institute of Professional Counsellors, 2011; Chu, Saucier, & Hafner, 2010; Yadav, 2010; Maulik, Eaton & Bradshaw, 2011; Kaynak, Lepore, & Kliewer, 2011; Norris, Friedman, & Watson, 2002). Social connectedness:

- Enhances opportunities to find out information essential to disaster response;/li>
- Provides opportunities for problem-solving, emotional understanding, and acceptance;
- Increases sharing and processing of traumatic experiences;
- Helps to normalise reactions and experiences;
- Engenders mutual instruction about coping.

All of this can lead to the community efficacy that we have just discussed. There is just one problem: there is very little empirical research on how to translate this well-validated principle into Psychological First Aid interventions, so providers of Psychological First Aid are called upon to get creative about how to enact this principle.

Lack of connectedness breeds trauma reaction

Soldiers have been observed to experience loneliness and emotional distancing right before severe emotional distress sets in (Solomon, Mikulincer, and Hobfoll, 1986). In the wake of the 9/11 attack and collapse of the Twin Towers in New York and also following terrorist attacks in Israel, one of the most common coping responses was to identify and link with loved ones (Bleich et al, 2003). Connections with loved ones being delayed following the London bombings was a major risk factor for subsequent trauma (Rubin, Brewin, Greenberg, Simpson, & Wessely, 2005). And research on disasters and terrorist attacks in countries as disparate as the United States, Israel, Mexico, Palestine, Turkey, and Bosnia all show that social support is related to better emotional well-being and recovery following mass trauma (Galea et al, 2002; Bleich et al, 2003; Norris, Baker, Murphy, & Kaniasty, 2005; Hobfoll et al, 2007). Mental health professionals with much disaster experience all agree: helping connections happen as quickly as possible following a mass trauma, and aiding people in maintaining those connections, is critical to recovery (Litz & Gray, 2002).

Psychoeducation and connectedness skills in three parts help adolescents

Children and adolescents are no different than their support-seeking parents. When Cambodian adolescents immigrating to the United States during the Pol Pot regime were reunited with at least one family member, they fared better in terms of lower levels of PTSD, depression, and substance abuse than children sent to foster homes. This was true even when the family member had been exposed to war and the foster family had not (Kinzie, Sack, Angell, Manson, & Rath (1986). Clearly, a priority must be to help reunite children and teens with family members, particularly, and interventions generally need to help war-exposed children and teens to increase the quantity, quality, and frequency of supportive encounters.

A group intervention conducted with war-exposed Bosnian adolescents directly targeted social support by offering:

a. Enhanced knowledge of social support, including information on the types of it (e.g., emotional support and closeness, reassurance of self-worth, feeling needed, reliable alliance and advice, and physical help and material support);
b. Help with identifying potential sources of such support
c. Training in how to appropriately recruit support (participants particularly found this last part worthwhile). (Cox, Davies, Burlingame, Campbell, & Layne, 2005).

Beware: potential problems in promoting connectedness

So, researchers, mental health experts, providers of care, and survivors all agree: it is vitally important to promote connectedness in disaster-affected individuals if we would reduce the incidence of PTSD and other trauma reactions in the wake of disasters. But is there a downside? Can this wonderful intervention of human connectedness ever limit or jeopardise our recovery efforts? Sadly, the answer is yes, on several counts. Providers of Psychological First Aid need to beware of the following potential problems in the offering of social support.

Support deteriorates quickly. As with funerals, there is often an outpouring of assistance, support, and comfort when a disaster affects a community. Survivors' psychological distress is mitigated by the expressions of concern and helping that they receive. The reality for most social supporters, however, is that at some stage they need to get on with their own lives, and they cannot realistically continue to offer support at the same level that they formerly were, so when the survivor, still mired in grief and shock, wishes to continue to take up the support, there is a mismatch, which requires further adjustment on the part of the survivor.

The Weekend Australian Magazine interviewed two survivors of the 2011 Queensland floods, Jean and Lloyd Warr, who in real life experienced the trauma we asked you to imagine being part of above: being stranded on the rooftop as the waters rise, and no one coming to the rescue. Lloyd Warr, speaking nearly one year on from the floods, acknowledged the factor of deteriorating support. "Yeah, that's been one of the hardest things," he said. "At the time, a lot of people said to us. 'We'll help you out, we'll get you through this, we'll be here until you are back on your feet.' But then the phone calls stop. People get on with their own lives." (Jackman, 2011, p16) Not all "support" is supportive.

Unfortunately, not all human beings are at a stage in their lives, or perhaps at a level of development, where they are able to offer perfect social support. Sometimes so-called "supporters" in fact undermine survivors' recovery through minimising their problems and needs, holding unrealistic expectations about recovery, giving invalidating messages, or blaming the affected person. This can be particularly detrimental to a person's efforts to come back to "normal" (Hobfoll & London, 1986). Obviously, it is crucial to identify early on who is receiving (or likely to receive) such support, or who – such as socially isolated people – may have poor support systems. Similarly, it will be difficult to make interventions connecting people to support systems when the communities that those systems were part of have been evacuated or destroyed in the disaster; intervention in these cases should be a priority (de Jong, 2002).

Attempting to counter the effect of community destruction, many countries have found that, with large-scale mass catastrophes, a successful intervention has been to convert places such as refugee camps into 'villages'. Villages have governing councils, welcoming committees, places of worship, places to go for services, meeting places, entertainment, and often a soccer field as well. Citizens of the 'village', not outsiders, fill the social roles, and enact them within the traditions and norms of their own cultures. Understandably, people who have things to take up their time, social responsibilities, and people that they can share experiences with are people who are more connected than people who are just sitting in their tent all day (de Jong, 2002). This relates to self-efficacy and collective efficacy, discussed above, and is at the centre of notions of connectedness.

Religious, ethnic, and tribal divisions become more salient when resources are scarce. Disasters and terrorist events don't just happen to "perfect" communities. They also occur in areas where, long before the disaster, there were schisms in the community according to religious, racial, ethnic, social or tribal lines. Whereas in good times a sub-population in a community may be able to tolerate another group, the threat of violence, death, and the concomitant loss of resources results in groups becoming more suspicious of one another and less tolerant. This means that, just when extra social support is needed, less is available. Hobfoll and his colleagues (2006) found that, during a period of high terrorist activity, both Jews and Arabs became more xenophobic, as their PTSD increased. Unfortunately, politicians often attempt to use this for political gain, trying to shore up support from "their" group, but creating greater societal division in doing so (Somasundaram & Jamunantha, 2002). Overall, despite the research gap, experts agree that there is enough experiential evidence from the post-9/11 environment to declare that promoting connectedness after disasters and terrorist activity is a "best practices" intervention (Hobfoll et al, 2007).

Linking in with yourself: connectedness and support

Cast your mind briefly back to a time in your life when you needed and received social support, but it was of a poor quality. Perhaps the "supporter" did not take your concerns seriously, minimising and/or trivialising them. Perhaps the person was judgmental or dismissive of you, or maybe they blamed you for the problem you were experiencing. Whatever it was, you did not feel "met", and their brand of support did not help you move past whatever you were dealing with.

What did you learn from the experience of being badly supported? If you were to train others in social support or disaster mental health response, what advice would you give your trainees to ensure that no survivor received the kind of "support" that you did?

Promoting hope

The importance of hope

There is a saying that, in a mass disaster, hope is one of the first victims. This raises the stakes in the recovery game, because many studies – and indeed the entire school of positive psychology – point to the crucial importance of retaining hope following mass trauma. Those who remain optimistic are likely to have better outcomes after experiencing mass trauma because they can retain a reasonable hope for the future (Seligman, 1992). Mass trauma is often accompanied by a sense that one's view of the world has been completely shattered (Janoff-Bulman, 1992), and that the future has been shortened. There is a feeling that "all is lost" (Hobfoll et al, 2007). As most people do not have prior experience of disaster, going through it quickly overwhelms their learned coping mechanisms. Not knowing how to cope is a fatal bullet to hope.

Hope: the definitions and the controversy

But how do we define that elusive characteristic of hope? A common definition in psychology is that hope is "positive, action-oriented expectation that a positive future goal or outcome is possible" (Haase, Britt, Coward & Leidy, 1992). It taps a sense of agency, or will, and the awareness of the steps necessary to achieve one's goals (Snyder et al, 1991). But is hope "action-oriented" for most of the world's population? Antonovsky (1979) claims that hope for most people is bound up with religion, and is not "action-oriented". In pioneering work examining Holocaust survivors, Antonovsky came to describe hope as "a pervasive, enduring though dynamic feeling of confidence that one's internal and external environments are predictable and that there is a high probability that things will work out as well as can reasonably be expected" (p 123).

The first definition of hope is based on efficacy. Antonovsky's sense of it is based on past experience, and often expresses the expectation that outside sources will act benevolently on one's behalf. Antonovsky did not emphasise the efficacy-based view, because he believed that that was singularly a white, upper-middle-class, Western way of looking at hope. Even some Westerners, he said, find hope not through such internal agency, but through belief in God, a responsive government, or just being lucky. So, for our purposes of examining how to promote hope as part of Psychological First Aid, which view is better? Is hope internally-based, or does it rest on externals?

The problem of linking hope with an internal sense of agency (self-efficacy) was seen after Hurricane Katrina in the south of the United States, when some residents were told to evacuate, and did not. They suffered the consequences. When those who survived were asked why they did not evacuate, the answers lay, not in a lack of their self-efficacy or internal agency, but in the knowledge that, being poor, they did not have external resources available for evacuation (that is, money to pay for accommodation or food elsewhere). Without that, they had little reason to hope for a positive outcome. Similarly, a study of veterans with combat-related PTSD found that the largest predictor of hope was employment status: an external factor. These findings mean that it is critical to provide resources (such as housing,

employment, relocation, replacement of household goods and payment of insurance reimbursements) to survivors to help them get back on track. Understanding this, the American state of Mississippi forced reluctant insurance companies to pay for damages as a mental health intervention. After Hurricane Andrew, again in the United States, the strongest predictor of PTSD for survivors was an external circumstance: the inability to secure funds to rebuild their homes. (Crowson, Frueh, & Snyder, 2001; Ironson et al, 1997)

What psychological first aiders can do to promote hope

As with some of the other elements, the provider of Psychological First Aid has a range of options at different levels for intervening in a helping way.

CBT and Positive Psychology. For those who believe that they have huge responsibility for somehow "causing" the disaster or not doing enough to avoid its consequences, remaining hopeful will be difficult. CBT (Cognitive Behavioural Therapy) can help to reduce such individuals' exaggeration of their personal responsibility, and thus allow hope to shine through.

The Learned Optimism and Positive Psychology model (Seligman, Steen, Park, & Peterson, 2005) attempts to identify strengths in people at risk, and amplify them. In their strength-building, positive psychologists concentrate on hope, and show survivor-clients how to dispute the catastrophic and exaggerated thinking that would otherwise undermine hope.

Normalising. As with promoting calming, normalising interventions help people to understand that their reactions are predictable, normal responses to an abnormal situation. An often effective normalising remark is to indicate to survivors and disaster-affected that most people recover spontaneously, without additional mental health interventions. This in itself instils hope, as the affected person can then counter thoughts such as "I'm going crazy," "I'm inadequate", or "my reactions are a sign that I'm weak and can't take it". Hope can also be fostered with techniques such as guided dialogue, restructuring irrational fears, managing extreme avoidance behaviour, and controlling self-defeating self-statements (Hobfoll et al, 2007).

De-catastrophising. An intervention component that is crucial to preserving and restoring hope, de-catastrophising can help counter negative thought patterns. It is best done early on through CBT-based interventions to correct the unhelpful cognitive schemas (Bryant et al, 1998). Many people catastrophise in order to prepare for the worst. While doing this can be adaptive in some cases, more often it leads to a failure to cope. The better option is to envision a realistic, yet challenging outcome. Paradoxically, statements of this sort (for example: "It will take months to rebuild my house") reduce distress more than unrealistic catastrophising (for example: "I'll never have a house again"). Facing the difficult truth of a long period of rebuilding is adaptive and may need to be accepted; asserting that one will never have a house again is maladaptive. The catastrophising person should be told that, as with so many intense post-disaster reactions, it is natural to do, but such thoughts should be identified and countered by statements based more in fact (Hobfoll et al, 2007).

Benefit-finding. A tendency to see the silver lining in even the dark clouds of the disaster is often associated with increased hope, and is fairly common among people facing multiple threatening events. It has shown to predict mental health adaptation months and even years later (Stanton, Danoff-Burg, Sworowsky, & Collins, 2001). Does this mean that psychological first aiders should go around telling all the victims of a mass disaster that they should look on the bright side (followed by why)? No, caution should be exercised with any such intervention, because survivors are likely to sense that their genuinely serious challenges to overcome are being trivialised or minimised. Beyond that, some studies have found benefit-finding to be related to greater PTSD, greater xenophobia, and increased support for retaliatory measures (Hobfoll et al, 2006). While the jury is still out on the evidence, the suggestion from mental health experts is to help people highlight strengths, and acknowledge benefit-finding that they may do spontaneously, rather than trying to persuade them to engage in it (Hobfoll et al, 2007).

Community-level interventions: building social-ecological resilience to foster hope. An important determinant of communities' capacity for recovering from disaster is how well they can mobilise assets, networks, and social capital, both to prepare for coming disasters and to recover from those which have already occurred. Different segments of the community which tend to have a leadership

role (e.g., churches, schools, community centres) can be instrumental in helping people to be more accurate in their risk assessment, in setting positive goals, in building strengths, and in helping them to tell their story. These sorts of interventions, in accordance with Seligman's model of Learned Optimism and Positive Psychology (1992), complement any CBT-based interventions, which encourage people not to dwell on irrationally negative thoughts and are solution-focused. The grand advantage of community-inspired initiatives is that they can develop and implement hope-building interventions, such as community-organised clean-ups, home visits, blood drives, and other needed initiatives that involve community members who would otherwise feel like the problems were too big for one person to tackle alone. In this sense, community-level interventions interface very well with individual-level ones to instil hope (Hobfoll et al, 2007).

Hope: where do you stand?

What is your opinion with regard to the controversy on hope: do you think hope is more reliant on belief in benevolent external factors (such as "God" or luck), or is it an internally-generated, action-oriented thing? Either way, what are the implications for your work in disaster relief, especially in mental health responding after a disaster? Which interventions to promote hope are you drawn to using? Why?

Summary

The foregoing discussion has outlined what is involved in each of Hobfoll's five essential elements of mental health disaster response – promoting safety, calm, efficacy, connectedness, and hope – and what considerations a provider of Psychological First Aid might want to beware of in setting up interventions in accordance with them. We now turn to the very practical sets of actions that spring from the principles (next chapter).

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Chapter 5

The Core Actions of Psychological First Aid

In the previous chapter we laid out five overarching principles that valid and effective Psychological First Aid. These principles were:

1. Promoting a self of safety
2 Promoting calmness
3. Promoting a sense of efficacy
4. Promoting connectedness
5. Promoting hope

Flowing from the five principles are eight core actions of Psychological First Aid that we now explore in depth, to enable practical effectiveness in a disaster setting. But first, here are the objectives for this chapter.

Objectives

By the successful completion this chapter, you will be able to:

1. List the eight core actions of Psychological First Aid, and explain what is involved in each of them.
2. Demonstrate how to initiate contact and engage with a potential helpee.
3. Name five actions which increase survivors' safety and comfort.
4. Explain what is involved in stabilising and orienting shocked or overwhelmed survivors.
5 Identify four types of information a psychological first aider should gather in order to assess needs and concerns.
6. List the four-step sequence of actions recommended in order to give survivors optimal practical assistance.
7. Show how to facilitate linking survivors to social support, including teaching about and modelling supportiveness.
8. Summarise the main reactions to trauma, and name at least four adaptive and four maladaptive strategies for coping with trauma reactions.
9. Name at least five common situations requiring referrals to other services, and explain how to help provide survivors with continuity in helping relationships.

The eight core actions of Psychological First Aid

We have examined the broader context in which Psychological First Aid is offered, and detailed the factors that determine where and how it happens. Chapter Four outlined the simple theoretical framework - Hobfoll's five essential elements - which informs service delivery. We can now study the groups of practical actions that spring from the elements. There are eight:

1. Contacting and engaging survivors
2. Tending to needs for safety and comfort

3. Stabilising survivors
4. Gathering information about needs and current concerns
5. Providing practical assistance
6. Connecting survivors with social supports
7. Giving information on coping
8. Linking survivors with collaborative services

(Brymer et al, under auspices of the National Child Traumatic Stress Network; National Center for PTSD, 2006).

Respect, dignity, and sensitivity: the core actions in context

Chapter Five is devoted to looking in greater depth at what is involved in each of the core actions of Psychological First Aid. Ultimately, most of the actions that a psychological first aider is encouraged to take revolve around the answers to a few simple, essential questions:

1. Does this action show respect for the person(s) on whose behalf it is being performed?
2. Does this action attempt to guard the privacy (including confidentiality) and dignity of the person(s) receiving it?
3. Is this action being taken with sensitivity towards the age, gender, culture, and racial group of the person(s) for whom it is taken?
4. Is this action conducted with compassion and concern for the needs of the person(s) who is/are to receive its benefits?
5. Is this action likely to help the person(s)?

If any of the answers are "no" in regard to a proposed action, then it is probably not an efficacious intervention, and may even be harmful to the recipients. It probably is not Psychological First Aid. We will be working with the general framework set out in the often-cited *Psychological First Aid: Field operations guide* (Brymer et al, 2006).

Contacting and engaging survivors

Your goal: to either respond to or initiate a contact with a potential "client" (helpee) in a helpful, empathetic, and respectful manner.

At this early stage of assistance, you have two tasks if you would help survivors and those affected by a disaster: to introduce yourself, and to ask about the person's immediate needs – ensuring with both tasks that confidentiality is protected.

Do:

Introduce yourself

1. Treat those approaching you as the highest priority to engage with.
2. Understand that first impressions count, and if the encounter is positive for the person, they will be willing to receive more help later.
3. When you approach survivors, give your name, title, and say what you are there to do (for instance, check that people are ok).
4. If initiating the contact, ask permission to speak with the person for a few minutes and call them by their title (i.e., usually "Mr" or "Mrs") and surname.
5. "Slow and easy" does it: your calm, well-modulated voice (not loud or agitated) will help build the trust necessary to accept your help.

6. If your offer of help is refused, let the person know where they can find a psychological first aider, should they want help later.
7. With families, ask who the spokesperson is, and speak to that person.

Ask about immediate needs

1. Try to find as "private" a place as possible, in order to guard confidentiality as well as possible; this may be challenging, but confidentiality is extremely important!
2. Ask the person to sit down, and ask them whether they would like, say, juice or water (if available).
3. Give the person your full attention.
4. Explore whether there is any pressing need that requires immediate attention (medical needs have highest priority).
5. If speaking with a distressed child, try to find their parent/caregiver as soon as possible, and let that person know about your conversation.

Don't:

1. Interrupt conversations in order to try to help.
2. Assume that you will be welcomed with open arms; some people may not feel safe or out of shock enough to talk to you.
3. Touch the person (taboos against this, particularly if the person is of the opposite sex, exist in many cultures. Until you know what is acceptable in the person's culture, touch is risky).
4. Stand too close, invading the person's "personal space".
5. Make prolonged eye contact.
6. Call the person by their first name (unless they invite you to do so).

Tending to needs for safety and comfort

Your goal: to restore or enhance immediate safety and to offer physical and emotional comfort.

Promoting a sense of safety in the aftermath of a disaster is important because feeling safe and comfortable diminishes anxiety and distress. Included in this component is information that helps people to feel safer: both at a community level (such as what disaster relief workers are doing to make a situation safer) and at a personal level (such as finding out information about where a missing loved one is). Assistance to survivors to help them deal with issues related to death, such as death notifications and body identifications, also comes under this group of actions.

In general, the concept is to encourage people to do things that are practical, active rather than passive, and as familiar as possible. Information that would enhance safety should be current, accurate, and avoid exposing people to excessively upsetting content.

Do:

Tend to immediate needs for physical safety and comfort, and to needs for disaster response activities and services

1. Ensure that the current environment is as safe as possible. Evacuees may be out of the immediate disaster zone (say, where the fire, flood, or earthquake has ravaged the community), but you may still need to resolve safety concerns such as broken glass, spilled liquids, sharp objects, and objects that could cause people to trip and fall.
2. Make sure that children have a safe, supervised area to play in.
3. Help senior and disabled survivors by:
    a. Ensuring that there is adequate lighting and protection against slips, trips, and falls
    b. Keeping all their aids (e.g., walking canes, hearing aids, eyeglasses) with them

4. Ask whether those you are helping need assistance with grooming or hygiene issues, such as bathing and dressing, or daily activities, such as eating.
5. Attempt to get accurate information about a person's need for medication. If they don't have a list of current medications, try to see where it could be obtained, and ensure that they have a copy with them during the disaster aftermath. Does this person need to go onto your "Special Needs" list?
6. Contact relatives, if possible, to get more information on nutritional and medication needs.
7. Stay with anyone requiring urgent medical attention until help arrives.
8. Look out for people not coping, either because they are making threats to themselves or others, or because they are in shock (identifiable by pale, clammy skin, weak or rapid pulse, dizziness, glassy eyes, shallow or irregular breathing, unresponsiveness, or lack of bladder/bowel control). If anyone is agitated, restless, or confused, seek immediate medical attention.
9. If in your judgment the people you are assisting would be able to receive information (i.e., they seem able and ready to comprehend it), give them information about:
    a. The disaster (if it is still unfolding)
    b. What is being done to help them
    c. What services are available
    d. What stress and emotional reactions they may be experiencing
    e. What they need to do next
    f. How to take care of themselves and their family members
10. Use clear, simple language, avoiding technical terms, and answer pressing questions and concerns – but only with information that you do actually have. "Inventing" information will not help!
11. Work out ways to make the physical environment more comfortable. For example, explore what you can do with factors like lighting, temperature, air quality, and furniture. Wherever possible, engage those whom you are helping in order to reduce their sense of helplessness or dependency. A family could choose, for example, how to arrange what little furniture they may have access to at a shelter, and a member could be chosen to help you go retrieve bedding and other needed supplies, as opposed to you merely doing it for them.
12. Try to secure soft, cuddly toys for children, as these can help them to soothe themselves.
13. Pay attention to the health needs of survivors, some of whom may have physical illnesses, blood pressure or respiratory issues, susceptibility to falls, sensory loss (visual or auditory), mobility issues, or cognitive problems (such as problems with attention, memory, or concentration).
14. Note that some people, such as seniors or the disabled, may have been ok in their home environment, but are challenged to be comfortable now. For example, someone may be able to bathe themselves, but not cope with the queues for the showers. Another person may have hearing devices that work fine at home, but in the noisy environment of a shelter, do not allow in "the right noise" (i.e., human voices as opposed to high-decibel background noise). Still others may simply be confused in an unfamiliar environment.

Help people make connections

1. Help individuals and groups come together with survivors who are coping well, as being around such people is soothing and reassuring.
2. Place children near adults who are relatively calm and coping. Research has shown that children take their cue from adults as to how to respond to adversity (Camilleri, P., Healy, C., Macdonald, E., Nicholls, S., Sykes, J., Winkworth, G., & Woodward, M., 2007).
3. Encourage people who are coping well to talk with others who are not. They can be helped to find commonalities in experience (for example: being from nearby neighbourhoods or having same-age children) about which to converse. Reassure the recruited conversationalists that it is good for both parties – themselves as well as the distressed people they will speak with – to make a social connection; helplessness and isolation reduce as a result.

4. Facilitate children joining in social activities like collective art projects, board games, sports, and activities such as reading out loud.
5. Children refuel emotionally from their parents, so reconnecting children with their mother and father (or sometimes other caregiver) is of paramount importance to their sense of safety and comfort. Ask unaccompanied children for: their name, parent and sibling names, address, and school, and let the appropriate authorities know. Support them while caregivers are being located, or in cases where caregivers seem too emotionally overwhelmed to give emotional support to their children.
6. Give children information about what to expect and who will be looking after them (if not you) in simple but accurate language.
7. Set up a child-friendly space (a corner might help to contain them) away from traffic, and staff it with people who know how to work with children; monitor children to ensure that they do not leave with an unauthorised person. Stock the space with:
    a. Simple art materials, such as paper, scissors, crayons, glue, tape, colouring books
    b. Activities such as Leggo, play dough, team games, paper cut-outs
8. Recruit older children to play with and serve as mentor-coaches to the younger children.
9. Organise time/space for older children and adolescents to get together to relax and socialise.

Keep survivors from being re-traumatised

1. Try to protect survivors from exposure to further traumatic incidents, and also reminders of the traumatic event that they have just survived/witnessed. This includes sounds, sights, and smells that may remind them of the original incident, or be otherwise frightening.
2. Help keep the media, onlookers, and any solicitors from disturbing survivors' privacy.
3. Discourage survivors and disaster-affected people from excessive viewing of the disruptive event on the media.
4. Encourage parents to monitor and limit their children's viewing of media coverage of the event, coming to them instead for updates (which should be phrased in ways that help clarify unfolding events but do not upset children).

Help survivors deal with missing loved ones

1. Recognise the intensity and variation of feelings – ranging through denial, anger, guilt, despair, worry, shock, hope alternating with hopelessness – which survivors experience when a loved one is missing. Reassure them and also children that police, other disaster workers, and sometimes even family members, are doing all they can to locate the missing person.
2. Brief families with a missing loved on by giving them information on:
    a. Locations for updated briefings
    b. Plans in place for reuniting survivors
    c. Websites such as the "Safe and Well" page on the Red Cross website (www.redcross.org)
    d. Other official sources of updating information, such as local police, official radio and television channels, and any other governmental sites (physical or online) which may help
3. Go over with the family any pre-disaster plans they had for meeting up after an emergency (including names of meeting places and/or communities and relatives' homes), plans for evacuating schools and work, and any relevant telephone numbers.
4. If desired, help the family file a missing persons report; limit children's exposure to this.
5. If a child needs to be interviewed regarding the search for the missing person, you can help by insisting that the interviewer be trained in asking such questions to children; offer to be present if the family/child wishes.
6. Try to persuade family members to be respectful of one another's different beliefs regarding the fate of the missing loved one; being more worried is not a sign of loving the missing one more.
7. Be honest with children that there is concern for the fate of the missing loved one, rather than giving the child false hope that the person is still alive, especially when available information suggests the opposite.

8. As always, check with children to ensure that they have understood, and ask whether they have any questions.

Help survivors deal with issues related to death

1. When there are mass casualties and deaths in the aftermath of a disaster, consult with local community cultural leaders in order to find out about cultural norms related to traditions, practices, rituals, managing emotions, and honouring the dead.
2. Do not assume that all families will react the same simply because they come from a given cultural group; attitudes about death, funerals, and appropriate grieving vary widely.
3. Recognise that feelings can range from sadness, anger, guilt, regret, to missing the person who has died and seeing them in dreams; the intensity that is common at the acute grief stage is a healthy response, marking the significance of the death.
4. All acutely bereaved – children as well as adults – must be treated with compassion, respect, and dignity, and all grief reactions accepted.
5. While there is no one "right" way to grieve, grief does put people at risk for increased use of substances, including medications, alcohol, and tobacco – and these definitely don't help the survivor. Help bereaved people to understand the importance of doing good self-care, and of seeking professional help if necessary.
6. Discuss with survivors how their cultural or religious beliefs may influence how people grieve, and how given rituals may or may not be satisfying to some family members.
7. Note that children express grief differently than adults, and may appear to be unaffected, continuing to play and only expressing grief for certain periods of the day; their grief may be every bit as strong as the adults'.
8. If you are with a child or adolescent who seems to be struggling for words to describe how they feel, invite them to do a calming activity such as drawing, listening to music, or reading. The person may wish to be alone (help with this only if it is safe to give them privacy). Your role as they come into readiness to talk is to simply sit close by, listening and not probing.
9. You can reassure them by letting them know that their experiences are normal and to be expected, and that periods of sadness, anger, and/or loneliness may continue for some time.
10. Let them know that if they feel so bad (i.e., depressed) that they have trouble with daily functioning, they should talk to a counsellor or minister who specialises in grief, and that they can get referrals to services through their doctor, local department of mental health, or local hospital.
11. Check children's understanding of death, as younger ones especially may not realise that death is permanent; they may be concerned about something bad happening to another member of the family.
12. Adolescents need to be monitored, as their grief reaction may trigger rage or impulsive, reckless behaviour.
13. Young children need to go back to their normal daily routines as quickly as possible after the death of a parent or caregiver. They are likely to be upset by even small changes in routine, and express anger to the new caregiver, especially if they are being disciplined. Caregivers need to take into account how they are missing the parent, and provide extra comfort.
14. Caregivers may need to deal with adolescents' sense of unfairness and anger over extra family duties, which prevent them from doing normal things. As soon as possible, there should be discussions with them about how they can regain some of their freedom and independence.
15. In talking with children and adolescents about the death of a parent or loved one, some pointers may be helpful:
    a. Children need to know that they will still be loved and cared for
    b. They need to be given a listening ear when they are ready to talk, but not pushed or made to feel guilty before they are ready
    c. They need to know that the death was not their fault
    d. They need to have simple, honest answers to questions, and about funerals and other issues
    e. They may need to be given the answers over and over again.

Helping with spirituality and grief

1. A useful question for survivors in grief is, "Do you have any religious or spiritual needs at this time?"
2. Ask survivors if they would like to see a clergy member of their faith.
3. Members of the clergy can be very helpful in providing replacement religious objects, such as prayer beads, sacred texts, or other devotional objects.
4. Some survivors may want to hold group religious observances; your role as a psychological first aider can be to help them find a suitable place. At a shelter, you might need to provide information to those in charge about the needs for space and for religious items to conduct the worship session.
5. If you are invited to join in with people whose way of worshipping is very different from your own, you can still participate in a supportive way by merely standing in silence while the group prays. This can be very helpful in building relationship with the survivors.
6. Ask about specific cultural/religious needs around practices related to the care of dead bodies; survivors may wish to consult with a clergy member from their faith, especially in complicated cases where, say, the body has not been recovered.
7. If survivors are grieving very loudly and with great expression, it may be normal for their culture/religion and not be a sign of them being out of control. You may, however, wish to move them to a more private space in order to keep them from upsetting others.
8. Spiritual distress may be evident when survivors and disaster-affected people express anger with their own religious beliefs. If the distress is so strong that it appears to be keeping them from functioning well, you can ask if the person would like to be referred to a member of the clergy.
9. Casket/burial issues may be tricky for members of some faiths, as local laws may go against what their religion dictates should happen. For example, some religions forbid autopsies, but some communities have local laws which mandate them when there has been a violent death, or when the cause of death is unclear. As a psychological first aider, you can help by asking, for example, if there are waivers for groups or families who do not wish to have an autopsy.
10. The issue of whether children should attend a funeral is somewhat delicate. They should be allowed and even encouraged to attend, but not pressured to do so. If they are not allowed, they are excluded from an important family event. If they do go, they can become overwhelmed, and need to have a supportive adult with them so that they can leave, perhaps temporarily. It is best for them to be able to sit near a support person of their choice, who may be able to pay attention to them during the service should they need it. They should be told what will happen at the service beforehand.
11. It is probably best if children do not try to touch, or even view the body, and they may need to be reminded that the person is not in distress.
12. If a survivor or disaster-affected person is exhibiting signs of traumatic grief, it can complicate their grieving, interfering with positive remembering. The person can be advised that it may be helpful to talk to a mental health professional or member of the clergy. Symptoms of traumatic grief include:
    a. Intrusive, upsetting images
    b. Withdrawal from close relationships
    c. Avoidance of activities which bring reminders of the death
    d. (In children) repetitive play that includes themes of the death.
13. Survivors who receive a death notification need to be supported. You can do this in several ways, by:
    a. Giving family members the time they need to process the news
    b. Understanding that there may be strong reactions
    c. Seeking assistance from medical support personnel if necessary
    d. Getting help from authorities or mental health professionals if individuals are at risk of harming themselves or others

e. Making sure that social supports (friends, other family members, neighbours, clergy) are available to the notified family
f. Staying with the family – say, by sitting at the same table – in cases where authorities are addressing a large crowd of people (for instance, after an airline crash)
g. Being sure to stay with an unaccompanied child who is being told that their parent or caregiver has died. Stay with the child until they can be reunited with other family members, or be attended to by appropriate child protection workers
h. Noting that children may have very varied reactions to hearing of a loved one's death, including crying or pretending that they didn't hear, not speaking for some time, or being angry with the person that gave them the news.
i. Advising caregivers that adolescent responses to news of a loved one's death may include rage and risky behaviours, such as reckless driving, using alcohol and drugs, or promiscuous sexual behaviour. Caregivers can be urged to tolerate some expressions of anger, but not behaviours which would endanger the teen. If a teenager expresses suicidal thoughts, these should be taken seriously and tended to immediately by mental health professionals.

14. In supporting survivors who need to do body identification:
    a. You may expect a wide range of mental and physical reactions after family members view a body, from screaming or hitting someone to shock or numbness. People may vomit or faint.
    b. Note to caregivers that children should not be involved in body identification, especially as the often disfigured body can be overwhelmingly upsetting. Children can be told, rather, that the loved one is not in pain, that he or she loved the child, and that the child will be taken care of.

Don't:

1. Reassure people that they are safe, or that certain goods and services will be available, unless you know that that is the case.
2. Promise children that they will see their caregiver soon if you cannot be sure about that.
3. Tell children that a loved one is alive when there is a chance that the person has died.
4. Say inappropriate things to a survivor when a loved one has died. Insensitive remarks include statements such as:
    a. You'll feel better soon.
    b. We're never given more than what we can bear.
    c. What doesn't kill us makes us stronger.
    d. You should get over this.
    e. It was for the best.
    f. You are strong enough to get through this.
    g. She is better off now.
    h. Everything happens for a reason.
    i. It could be worse; you could have lost more family members.
    j. It was his time to go.
    k. Thank goodness he went quickly.
    l. You did all you could; you need to relax.
    m. It's good that you survived.
5. Push children, or anyone, to talk about their grief following on from a death.
6. Be afraid to say, "I don't know".
7. Attempt to talk survivors out of believing/hoping for a miracle survival of a loved one. Clinging to unrealistic hope is one way of continuing to function in devastating circumstances. (General framework adapted from Brymer et al, 2006).

Think about it

The list of strategies for helping people to feel safe is long. Which strategies do you feel the most comfortable to use? Which ones would represent the greatest stretch for you? What can you do now to increase your comfort level with using these?

Stabilising survivors

Your goal: to help orient disoriented survivors, and to help overwhelmed survivors become calm.

While strong reactions to a catastrophe or disruptive event are normal, predictable, healthy responses, if people are exhibiting extreme anxiety and arousal, or the opposite – numbing – their ability to manage everyday functioning is impaired, and they may be need your assistance. You can help by using stabilising and grounding techniques (see below). If these do not calm them, you can help them seek additional supportive intervention. It is helpful to understand about the role of medications in stabilising disaster-affected people.

Do:

Calm emotionally overwhelmed people

1. Check for signs of disorientation or overwhelm, such as:
    a. Not responding to questions or commands
    b. Shaking, trembling, or showing other uncontrollable physical reactions
    c. Seeming vacant or looking glassy-eyed
    d. Exhibiting frantic searching or worry
    e. Appearing disoriented
    f. Engaging in risky behaviours
2. Enlist the help of family and friends to comfort someone when the person is either extremely agitated or withdrawn, or in the throes of extreme panic or fear.
3. Try to address the person's primary concern (for example: are they having flashbacks to the event?) rather than just telling them to calm down.
4. Make sure that emotionally overwhelmed children are with stable parents. When parents aren't coping well, attempt to stabilise them.
5. Stabilise highly distressed people by following this procedure:
    a. Give the person a few minutes before intervening (you can let them know that you'll be back in a few minutes to check on them and see if they need any help then).
    b. Remain calmly, quietly available near the person rather than attempting to talk with them.
    c. Help the person to focus on specific goals, thoughts, and feelings which they can manage.
    d. Give the person information that can help them get used to the surroundings, such as how things are organised at the shelter (or wherever they are), what will be happening, and what steps they might wish to take.

Orient people who are emotionally overwhelmed

1. Help adults to understand that they may have strong feelings coming and going in waves.
2. They may become easily startled: the body's "alarm" system after a shocking experience.
3. Suggest that calming routines, such as going for a walk or deep breathing, may be the best way to recover, and that friends and family are crucial supports to help calm down.
4. Tell children that there are many adult-responders who are working together so that people can recover.

5. Remind teens that they should talk things through with a parent or other trusted adult before doing anything risky.
6. Ground extremely agitated people who are crying intensely for an ongoing period, losing touch with their surroundings, or rushing their speech.
7. Get disoriented people to look at you, listen to you, say who they are, and describe the surroundings.
8. Use a grounding procedure similar to the following:
    a. Explain to the survivor that a horror-filled experience can cause people to be unable to stop thinking about the event; it can overwhelm them. To feel better, they can use "grounding" to turn away from upsetting thoughts to the outside world. Show them what to do.
    b. Demonstrate sitting comfortably with arms and legs uncrossed, breathing in and out slowly and deeply.
    c. Model looking around the room and naming five non-upsetting objects that you can see: e.g., "I see a blanket; I see a water bottle; I see a baby; I see a table; I see a red dress."
    d. Breathe again slowly and deeply.
    e. Model naming five non-upsetting sounds that you can hear: e.g., "I hear men talking, I hear a toddler slurping his food, I hear a clock ticking, I hear someone washing dishes, I hear children playing."
    f. Breathe again deeply and slowly.
    g. Model naming five non-upsetting things that you can feel: e.g., "I feel the back of my legs being supported by the chair, I feel a breeze on my cheek, I feel my toes on the floor, I feel my hair on the back of my neck, I feel my arms resting on the chair."
    h. Breathe in slowly and deeply again.
    i. With children, ask them to name colours that they see.
9. Consult with medical personnel if the person is still not emotionally stabilised after the above procedure; they may need medication.

Understand the role medications play in stabilising survivors

1. Know that medication is a "last resort" option for stabilising acutely traumatised people. Most people respond to Psychological First Aid efforts, generally, or the above grounding techniques, specifically.
2. Medication is sometimes used for specific complaints, such as sleep or control of panic attacks.
3. Some pre-existing conditions are worsened by medication. These include depression, anxiety, pre-existing PTSD, and schizophrenia.
4. Disruption to survivors may mean that they are without normal access to their doctors, pharmacists, psychiatrists, and medications.
5. When referring someone to a doctor, try to gather information from the survivor – or their family or friends if they are too distressed or confused - such as:
    a. Which medications the person is currently taking
    b. Which current medications require medical monitoring
    c. What sort of access the person has to prescribed medications
    d. How compliant they are with taking their medications
    e. Whether there are any substance abuse issues
    f. Any known information about ongoing medical or mental health issues

Don't

1. Tell survivors to "calm down" or to "feel safe"; it doesn't work.
2. Don't take over for parents or undermine their authority when helping to calm agitated, overwhelmed children.

Linking in with stabilising

The grounding techniques for stabilising are practical tools to calm and/or orient someone, but to apply them in the field, you need to be able to call on them spontaneously: meaning, that you know them and can implement them fairly well at short notice. How could you conduct a practice period for yourself in which you set up a situation and practice the techniques?

Gathering information about needs and current concerns

Your goal: To find out what your client's immediate needs and concerns are, and to collect additional information, so that Psychological First Aid interventions can be tailored.

In most disaster settings where Psychological First Aid takes place, you will be limited in your information-gathering capability by time, the number of people with needs, the extent of the concerns, and other issues. You are not likely to be able to do formal assessments, even if you are trained in them. Your information-gathering is thus geared around establishing the need for any immediate referrals, finding out what other services are needed, and flexibly organising Psychological First Aid interventions tailored to meet those needs. The gathering of information continues in a feedback loop throughout your extending of Psychological First Aid to a client. That is, you gather information, plan and implement interventions, get feedback (more information) from clients, implement refined interventions, get more feedback, and so on.

Do:

Gather information about severely upsetting experiences and perceived ongoing threat

1. Find out from survivors about how catastrophic their experiences were by asking where they were during the disaster, whether they got hurt, whether they saw anyone else get hurt, and how afraid they were. The more severe the experience, the more at-risk the person is for later PTSD or other ongoing mental health issues.
2. At this stage, avoid asking survivors in-depth questions about their experiences. If they spontaneously begin to disclose major details of their trauma or loss, respectfully tell them that you need basic information now so that you can help them meet their current needs, and that you can arrange an opportunity for them to talk about what happened in an appropriate environment later (and then be sure to do it).
3. Losing a loved one under traumatic circumstances makes the grieving process more complicated. To enquire about the death of a loved one, you can ask whether someone close to the person got hurt or died as a result of the disaster. And clarify: "Who got hurt or died?"
4. Provide emotional comfort, and information about coping (see section, "Giving information about coping", below), and ensure that the bereaved person has social support. Offer to meet with them again.
5. When survivors seem worried about ongoing threat post-disaster, you can ask whether the person needs information:
    a. To help them understand better what has happened
    b. To help them keep their family safe
    c. To find out what is being done to protect the community

Identify separations, health conditions, and losses

1. Get information about whether survivors have been separated from loved ones by asking whether they are worried about anyone at the moment, and whether they know where the person is. Clarify whether it is someone really important like a family member or friend.
2. Where a survivor is experiencing a separation, go through the practical steps to reconnect them, as detailed in the "Tending to needs for safety and comfort" section.
3. As pre-existing mental or physical health conditions are an additional stressor in the aftermath

of a disaster and also put people at higher risk for worsening health later, it is important to prioritise medical concerns. Survivors can be asked whether they have a physical or mental health condition that needs attention, whether they need any medications that they don't have (including needs for prescription refills), and whether they can or need to get in touch with their doctor. Again, your job is to provide the practical help that will connect them with needed resources.

4. Consistent with the COR (Conservation of Resources) Theory (Hobfoll, 1989), survivors experiencing extensive material losses and adversity may have a more difficult recovery, as they deal with complicating feelings of depression and hopelessness. To gather information about this aspect, you can ask people whether the following were lost or destroyed in the disaster:
    a. Their home
    b. Other personal property (cars and boats, for example can have high value)
    c. Any pets
    d. Their business or school (or even: whole neighbourhood, as in some of the Christchurch New Zealand suburbs, in which liquefaction ruined some neighbourhoods where the earthquake had spared the homes)
5. Emotional comfort, practical assistance, and information about coping and garnering social support will be the most helpful interventions in these cases.

Identify psychosocial needs and concerns

1. Often in a disaster, people experience "survivor guilt", wondering why they survived and someone else did not. They may feel guilt or shame that they did not do enough to prevent the disaster, or to save others' lives. Such intense emotions are difficult for any age group, but may be especially challenging for children or adolescents who are either unable or too ashamed to discuss how they are feeling. Observe people carefully for signs of guilt or shame, and if you detect any, use an intervention like, "You seem to believe that you could have done more to prevent this", or "It sounds like you are being very hard on yourself about this."
2. Survivors with guilt and shame experiences need information on how to cope with those emotions (see section, "Giving information about coping"), and also emotional support.
3. One of the highest concerns for a psychological first aider is when survivors and disaster-affected have thoughts of self-harm or harm to others. You can preface your enquiry about this with an acknowledgement that situations like the person is in can be overwhelming. Then ask whether they have had any thoughts about harming themselves, or about harming anyone else. If they have, the situation requires immediate medical/mental health attention, and is so important that you must stay with the person who has acknowledged such concerns until the correct personnel arrive on the scene to manage them.
4. As noted before, a key resource for recovering from a disaster is perceived social support, so an important line of enquiry is whether the person has family members, friends, or community agencies that they can turn to for help with the problems they now face.
5. If the survivor's social support resources seem inadequate, your job is to help them connect with services and supports that are available, and to give them information about coping, and about how to enhance their social support. Schedule a follow-up meeting.

Establish whether there is history of either substance abuse or trauma

1. Identify issues of prior alcohol or drug use, as being exposed to trauma and the adversity of a disaster can cause a relapse, or lead the person to new forms of abuse. Ask whether:
    a. The person's use of alcohol, medications, or non-prescription drugs has increased since the disaster
    a. Whether the person has had any issues with alcohol or drugs in the past
    a. Whether they are now experiencing withdrawal symptoms from any substance
2. Information about coping and social support, help with connecting to appropriate services, and a follow-up meeting can be offered to those with concerns. Withdrawal symptoms require medical attention.

3. Similarly to a history of substance abuse, survivors with prior exposure to trauma or to the death of loved ones are at higher risk for mental health problems, not only in the form of more severe post-disaster reactions now, but also as prolonged – or even renewed – trauma and grief further down the recovery track. Ask survivors whether they have ever experienced a disaster or something bad happening to them before, and whether anyone close to them has died.
4. Again, for those at-risk from this sort of history, the best set of interventions includes information about grief and other reactions post-disaster, information about coping and social support, and the offer of a follow-up meeting.

Find out whether any special individual or family events were disrupted

1. Survivors can be especially upset when mass incidents disrupt special events that were coming up in their lives (see Osofsky, 2008, for a recounting of how she offered Psychological First Aid to a responder and his family demoralised about Hurricane Katrina's effect on the daughter's education possibilities). Events like weddings, graduations, even birthday celebrations can be affected. Ask survivors whether there were any special events coming up that were disrupted by the disaster. Information about coping and strategies to assist with practical help are needed.
2. To make sure that you have not missed anything, ask an open-ended question at the end of an information-gathering meeting. You can say something like, "Is there anything else that you are concerned about or would like to tell me?" When people name multiple concerns, get them to prioritise them, so that you know which issues to address first.

Don't:

1. Press survivors to talk in a detailed way about trauma or loss.
2. Ask for a history or in-depth description of prior trauma or loss, mental health issues, or substance abuse. Do give clear reasons why you are asking for any information about it.

Linking in with your interviewing skills

What is your experience of gathering information in an interview situation, such as above? Much of the information that you are asked to gather is sensitive. How comfortable are you with asking questions about, for instance, whether someone close to the interviewee died, or whether someone has had thoughts of self- or other-harm? One way to move through the discomfort is to grab a trusted friend or family member and ask them to be the "survivor". You be the psychological first aider. Train your friend in their role a little. For example: set a situation such as "You are a 45 year old woman sobbing at a shelter because you have lost your home and you don't know where your husband is. You have had nightmares about being caught up in bushfires again, and feel very unsafe, even at the shelter" – or whatever situation you wish to practice with. "Interview" the person, and then ask for their feedback about how well you conducted the interview. Some criteria may be considerations such as whether it was done with sensitivity, respect, cultural appropriateness, and with regard to gathering sufficient information to be of assistance.

Providing practical assistance

Your goals: To give survivor-clients the greatest amount of practical assistance possible to address immediate needs and concerns, and To help them set themselves up to receive further assistance, as necessary, later.

As we discussed earlier, the problem with disasters is not just that people lose loved ones, properties, possessions, and business places/jobs. Those are terrible enough, but the deeper problem caused by the reaction to those losses is that people lose hope, and then any actions towards recovery are greatly impaired.

The personal characteristics that pre-dispose survivors to better mental health outcomes are

beliefs that the world is benevolent and that they will achieve the best outcome possible under the circumstances, confidence that life is predictable and "ok", and a sense of optimism engendered by hope. It is not only personal characteristics that determine outcomes, however. Research also shows that it is easier to generate and maintain a sense of hope when sufficient resources are available than when they are not (Crowson, Frueh, & Snyder, 2001; Ironson et al, 1997). In accordance with the COR (Conservation of Resources) Theory (Hobfoll, 1989), then, Psychological First Aid is most effective when it effectively provides people with needed resources, thereby restoring hope, and enhancing their sense of empowerment and dignity.

While psychological first aid providers attempt to engage clients in discussions of their needs throughout the period of contact, many survivors are too distressed to comfortably problem-solve alone. It is then the disaster mental health volunteer's job to re-teach people how to set achievable goals, thus reversing their feelings of inability to cope. Repeated (small) success stories can re-establish the sense of self-efficacy and hope necessary for full disaster recovery. The following four steps are recommended:

1. ***Identify survivors' most immediate needs.*** People may bring forward a range of needs; it is important to focus on one at a time. Someone may first need to eat, and then place a phone call to family to say that they are ok, for example. Other problems, such as locating missing loved ones or obtaining insurance payouts for destroyed property, may not be resolved immediately, but can be attended to when basic needs for food, shelter, and clothing have been met.
2. ***Specify the problem with the survivor.*** Make sure that that problem is understood and clarified by both parties (the survivor and yourself). Problems identified are problems capable of being addressed.
3. ***Create an action plan.*** The survivor will say what he or she would like to have happen; you may have additional information about available services, resources, or support. It will be helpful for you to tell survivors what they can realistically hope to accomplish in terms of potential resources, support, and procedures.
4. ***Help the survivor to act on the action plan:*** for example, assisting someone with completing needed paperwork or gaining an appointment with a needed service.

Connecting survivors with social supports

Your goal: To help survivors to set up brief or ongoing contacts with both primary and other support persons, including community support resources as well as family and friends.

Research is clear that high levels of social support received during and after adversity mean more favourable outcomes long-term: quicker recovery and lower incidence of mental health problems (Australian Institute of Professional Counsellors, 2011; Chu, Saucier, & Hafner, 2010; Yadav, 2010; Maulik, Eaton & Bradshaw, 2011; Kaynak, Lepore, & Kliewer, 2011; Norris, Friedman, & Watson, 2002). Moreover, people who feel well connected are more likely to offer social support, thus becoming an additional resource instead of a survivor in need of assistance. Social support can come in the form of emotional support, instrumental support (material things like food, clothing, shelter), informational support or advice, validation support (like when someone affirms your worth or shows you how you are productive, valued, and appreciated), or social/companionship support (like when one gives or receives visits and social contact) (Wills and Shinar, 2000).

As you – and others whom you help – offer social support, you create the social conditions that are essential for disaster recovery. Those with enhanced social connectedness enjoy such benefits as greater capacity for problem-solving; increased sense of being understood and accepted; more capacity for sharing experiences, concerns, reactions, and information about coping; and enhanced knowledge about matters related to disaster recovery.

Enacting this core action of Psychological First Aid involves doing things to facilitate people having connections with you and with each other, increasing understanding about how support is given and received, and modelling being supportive.

Do:

Facilitate access to primary and other support people

1. As discussed in earlier sections related to safety and comfort concerns, survivors' level of psychological functioning improves rapidly upon re-connecting with their primary sources of support. As soon as possible, help people to contact family members, close friends, and neighbours.
2. Other useful supports may include co-workers and people with whom the survivor has served in organisations or attended club meetings, such as bowling or tennis clubs, charitable organisations, or Returned Services League clubs. Clergy or fellow members of churches/temples/mosques/meditation groups may be invaluable sources of support.
3. Support people can be sought by phone, in person, by snail mail or email, and through web-based sites: some expressly set up in the aftermath of disasters to help foster contact, such as the "Safe and Well" page on the Red Cross site.
4. Encourage survivors to use people available on site (such as yourself and the contingent of psychological first aiders, other relief workers, and other survivors). You can facilitate introductions between members of nearby neighbourhoods, or survivors with commonalities, such as coming from a similar religious group or having same-age children.
5. Older survivors can be invited to help by reading to or playing with young children, while adolescents or younger adults can be invited to connect with elderly survivors who may appreciate the social contact or need assistance with daily activities.
6. Same-aged children can be brought together to play, and similar-aged teenagers can be facilitated to come together to socialise, or to help with younger children.

Help survivors understand about offering and seeking social support

1. Be attuned and able to recognise the many reasons why some survivors and disaster-affected people may not come forward to accept support. In addition to strong post-disaster emotions, they may be dealing with:
    a. Not wanting to burden helpers such as yourself or others, especially if they can see great needs all around them
    b. Not being clear about what they actually need in the way of support
    c. Suspecting that their emotions are very close to the surface, and that they will lose control if they talk about their own needs
    d. Believing that only "weak" people accept help
    e. Feeling isolated, or that no one would understand their plight anyway
    f. Receiving poor-quality support in the past, and fearing that it will be that way again (for example: having someone minimise or trivialise their problems, or be judgmental)
    g. Worrying about the response they will get if they ask for help (e.g., rejection, anger, judgment)
2. You can address the above concerns, but also help reluctant, withdrawn helpees by going over aspects of receiving social support with them, such as:
    a. thinking about what type of support they would find useful
    b. identifying whom they could receive it from
    c. working out how and when to ask for the help (timing, place, consideration of the potential support person's situation)
    d. naming points of etiquette in support-seeking (length of session, thanking the person, etc.)
3. Encourage all survivors (adults, adolescents and children) to draw near supportive people but not feel compelled to talk about the disaster, and to feel free to ask for what they need.
4. "Training" of other would-be supporters (such as adaptively coping survivors who want to volunteer to help others) can include discussions of:
    a. Ways that they can be helpful
    b. How they can identify someone to help
    c. The importance of attending with interest, care, and in an uninterrupted time/place

   d. How valuable it is for the receiver of the support to know that the giver is willing to meet with them again.
5. Recognise that children often wish to help their peers and others, and have a number of means at their disposal. You can encourage them to take such actions as:
   a. Playing sports and games with other children
   b. Helping younger children and brothers and sisters to calm down and feel happy by spending time with them
   c. Offering to help with clean-up, repairs, and general chores to support their family and community
   d. Talking to adults about how the adults can help them.
6. Supporting children does not necessarily mean getting them to talk about what is happening for them. Just playing with them, taking a walk, doing a joint activity such as art, book or magazine reading, or even just sitting in silence with them can be the support that they most need.

Modelling being supportive

1. Your most powerful "training" method about how to offer social support is your own supportive manner and behaviour. Survivors and others who would offer support can notice you using:
   a. Active and reflective listening skills. From paraphrasing and reflecting feelings and meaning to open questions, clarifying statements, and "minimal encouragers", you can be a potent example of effective supporting.
   b. Comments which affirm and validate survivors' feelings and experience and show compassion, such as "Going through something like this is so tough" or "No wonder you feel ___"
   c. Comments and questions which enhance survivors' sense of self-efficacy and empowerment, such as getting them to reflect on how they helped themselves feel better when things were tough in the past, or offering a few ideas (either on a handout or verbally) along with a question like, "These are some ideas that others have used in the past to deal with challenging situations. Do you think anything like that might work for you?"

Don't:

Focus on discussing disaster-related experiences in either offering support yourself or training others to. With Psychological First Aid, the focus is always on practical help, and meeting current needs and concerns.

Linking in with your support-facilitating skills

If you are a decent networker in your "non-disaster relief" life, you may already have recognised some transferable skills you have for connecting survivors with social supports: your networking skills. The quintessential social support skill, networking (really a group of skills rather than a single skill) involves doing many of the same things that you will do as part of this Psychological First Aid core action. It is about helping people by putting them in touch with those who can help them, and fostering the kinds of relationships where helping can flow freely back and forth between individuals, groups, and communities.

For now, take a moment to reflect on times you have engaged in networking in contexts other than disaster aftermaths. Recall the skills you used to successfully link in with others. Now bring your mind forward to the future: your next (first?) field deployment after a disaster. Imagine yourself moving through the setting and trying to help people connect with those who can help them. Which skills are similar in the two situations? Which skills may be different: found in one situation or the other, but not both? Which skills might you wish to develop further?

Giving information on coping

Your goal: To give survivors and disaster-affected people information about coping in order to reduce distress and foster adaptive functioning.

Disasters cause chaos not only in the outer environment, but through that, in the inner, psychological environment of survivors as well. Having one's personal world "turned upside down" causes disorientation, confusion, and the loss of a sense of competence to solve problems. To counter the effect of that and regain some control over one's life, survivors are immensely benefitted with appropriate information. They need to know about:

- What is happening with the unfolding event, what is being done to help them, and what services are available (refer to section, "Tending to needs for safety and comfort")
- Which reactions they and others around them are likely to have, and how to deal with them
- Information about coping in a positive (as opposed to maladaptive) way, including considerations for families.

This section explores the last two points: reactions to traumatic events and tips for coping.

Do:

Give information about common reactions to trauma

1. Let survivors know that their stress reactions are mostly common and predictable, and that they should lessen over time. Tell them that, if after one month, they are still having a reaction so intense that it is interfering with daily life they should consider taking up mental health services.
2. Provide survivors and disaster-affected clients with basic information about the different types of post-traumatic stress reactions, so that they know what to expect. These include:
    a. Intrusive reactions, where the traumatic experience comes back to the person's mind in the form of distressing images, thoughts, or flashbacks (where they feel like the event is happening all over again).
    b. Avoidance/withdrawal reactions, in which people try to avoid thinking, talking, or having feelings about the distressing event. This way of protecting oneself from the distress of the disaster can serve people, but as survivors avoid increasing numbers of reminding stimuli (places, images, activities, or even people), their lives become more restricted. Numbness and social withdrawal can accompany this reaction, which is counterproductive for recovery. Some become less interested in normally pleasurable activities.
    c. Arousal reactions, where the person's body reacts as if it is still in danger: for example, being jumpy, irritable, or easily startled; hypervigilance; inability to fall or stay asleep; concentration difficulties.
3. Review with survivors the role of the various types of "reminders" which can make everyday life more difficult while they are recovering from the disaster:
    a. Change reminders: those people, places, and things – even pleasant ones, but certainly distressing stimuli – that remind the person that life is different now. This could be anything from eating different food for breakfast to attending a different school.
    b. Trauma reminders: these can be sights, sounds, smells, places, certain situations, feelings, or even specific people which remind the survivor of the terrible event. Usually the reminding stimuli are related to the particular event: for example, wind after living through a hurricane, or the smell of smoke after surviving a bushfire.
    c. Loss reminders: the objects, sights, sounds, smells, situations, and activities that remind people of their lost loved one(s) or possessions. Anything from seeing clothing of the deceased person to walking by the site where one's house used to be can evoke intense emotions.

    All of the types of reminders, but especially trauma and loss reminders, can cause people to avoid the reminding stimuli, and thus be incapacitated at doing what they need to do in life.

4. Explore with survivors whether they are experiencing any of the more common reactions to a traumatic event:
    a. Physical reactions, such as bowel problems; stomach, muscle, or headache; chest tightness or hyperventilation, rapid heartbeat, dizziness, or appetite changes.
    b. Grief reactions, experienced by many who have multiple losses. For instance, someone may have lost their home and possessions and also a parent. The grief reaction may manifest in strong feelings of anger, sadness, regret, and guilt, often accompanied by intense longing for that parent.
    c. Traumatic grief reactions, which happen when survivors suffer the traumatic death of a loved one. Complicating the grieving process, such reactions lead survivors to obsessively wonder what the deceased's last moments were like, whether the death could have been prevented, whose fault it was, and so on. These keep people from adjusting to the death.
    d. Depression, occurring when grief reactions go on for an extended period, incapacitating people to deal with their lives through reactions such as greatly diminished pleasure from life activities, loss of appetite and ability to sleep soundly (or sometimes, sleeping too much), feelings of worthlessness and hopelessness, loss of energy, irritable mood, and (sometimes) thoughts about suicide. Many depressed survivors experience feeling demoralised, as they attempt to adapt to post-disaster circumstances and continuing adversity.

    All of the above reactions are made much more difficult by the inevitable hardships experienced by survivors after a disaster. Having to deal with, say, insufficient food or water, sudden homelessness, insurance payout struggles, having to move to a new area, or separation from friends and family can all intensify the survivor's experience of uncertainty, exhaustion, and anxiety.
5. When talking with children about their reactions, it is better to ask them to describe bodily sensations than feelings, as children may not have words for some of the emotions they are feeling.
6. If it is necessary to assess their emotional state, it is more workable to offer children a choice between several feelings, rather than posing an open question. For example, you could say, "Are you feeling lonely or sad now, or are you ok?"
7. Some children may prefer to draw on an outline of the human form where they are experiencing intense traumatic reactions (e.g., stomach, chest, or head).

Give information about different coping strategies

1. Distinguish for survivors between adaptive and maladaptive coping behaviours.
2. Adaptive coping techniques include:
    a. Seeking or offering social support; spending time with people
    b. Getting counselling
    c. Becoming part of a support group
    d. Getting adequate information on services, what is happening, etc.
    e. Tending to needs of the physical body for adequate rest, healthful food, and moderate exercise
    f. Relaxation, prayer, and meditation periods
    g. Engaging in pleasant activities, such as taking a walk, reading a good book, or working on an art or craft project
    h. Returning to a normal (albeit, new normal) routine as soon as possible
    i. Using positive self-talk to maintain optimism, stop distressing thoughts, and calm oneself down
    j. Recording impressions, thoughts, feelings, and experiences in a journal
3. Maladaptive strategies revolve around:
    a. Using alcohol or drugs to cope
    b. Withdrawing from family, friends, or activities
    c. Excessive use of television or computer games (a form of withdrawal)

   d. Overeating or not eating sufficiently
   e. Overwork
   f. Not controlling impulses towards anger, blaming, and guilt
   g. Not exercising or sleeping enough

4. Tell survivors that, once they know what their coping options are, it is easier to see where their coping strengths lie (e.g., good at eating well or maintaining an exercise program even when stressed). It is easier to understand negative consequences that would accrue from using poor (maladaptive) strategies, and people can make conscious choices about how they will cope, choices related to goals they have developed. Doing this enhances efficacy, as people feel empowered when they exercise personal control over their own adjustment.
5. Help survivors deal with guilt and shame by encouraging them to find less upsetting, more realistic ways of thinking about the situation. Some can be encouraged to imagine how they might respond to a dear friend who was expressing similar guilt, shame, or other toxic emotion. Could the survivor say those same things to him/herself? Children – and sometimes adults – need to be reminded that the disaster was not their fault. They didn't cause it; they didn't do anything wrong.
6. Help survivors deal with anger by suggesting that it is normal to have feelings – even intense ones – of anger and frustration post-disaster. Discuss how the anger may be serving them (say, by helping them to protect themselves and their loved ones), but also limiting them (say, by affecting their relationships or causing violence). Ask them which changes they would like to make to deal with their anger issues.
7. If survivors ask about anger management techniques, you can suggest that they review the following for appropriateness for themselves:
   a. Taking some "time out" to cool down
   b. Doing physical exercise to blow off steam
   c. Recording the event in a journal, or writing what's frustrating them and what they can do about it
   d. Talking to someone – a friend or a mental health professional
   e. Engaging pleasant, distracting activities, such as reading, prayer/meditation, listening to music, or even helping someone
   f. Reminding themselves that just being angry doesn't help achieve their goals
   g. Giving children and teenagers ways to express their angry feelings, such as through art, role playing or play, writing, or music
   h. Sorting out the frustration, if the angry person is a frustrated child: that is, mediate a dispute, look for a lost toy, etc.
8. Assist disaster-stressed people to re-establish restorative sleep. Sleep problems are possibly the most common stress reaction post-disaster: not only for survivors and disaster-affected people, but also for disaster relief workers (including psychological first aiders) and general community members. People tend to be hyper-alert, and find it hard to "turn off" the in-built alarm enough at night to sleep deeply. You can suggest that those struggling try:
   a. Drinking no caffeinated beverages in the afternoon or evening;
   b. Exercising every day, but not too late in the day
   c. Engaging in calming, relaxing activity before bedtime (such as deep breathing, prayer/meditation, listening to (soothing) music
   d. Cutting out alcohol, as it disturbs sleep
   e. Trying to establish a regular rising and going-to-bed routine (same time every day)
   f. Only taking short naps during the day, and not after mid-afternoon
   g. Seeking social support for ongoing concerns, as talking things through can help alleviate worry-caused sleeplessness (possibly not immediately)
9. Encourage parents to negotiate with traumatised children about sleeping arrangements. It is only natural for children exposed to a traumatic event to want to cling to and sleep with parents

for some time afterwards, to bolster their sense of safety. Allowing this for a period of time will help children overcome their trauma reactions. The parent can let them know that the children will go back to their own bed at a given time, but that at that time the parent can stay with them until they fall asleep.

10. For those with alcohol and other substance abuse issues, you can explain that using alcohol, drugs, or other medications to cope with bad feelings is a somewhat common reaction. Invite the person to name how such a habit may serve and also limit them. Aspects also usefully discussed are:
    a. Agreeing a safe pattern of use, or better yet, abstinence
    b. Exploring potential challenges in changing behaviour
    c. Noting whether a referral to substance abuse counselling or a detoxification program is needed

Consider the needs of traumatised families

1. Help families to understand that, apart from practical/financial assistance post-disaster, there are several ways that they can help themselves recover from trauma, and improve the family dynamic:
    a. By re-establishing, as far as possible, family routines (for example: wake-up and bed times, dinner hour, play time, and "family time").
    b. By dealing as soon as possible with any pre-existing behavioural or mental health problems, as these tend to worsen when individuals or families are traumatised. You can discuss previous strategies the family had before to manage behaviour, and how these could be adapted to the present conditions. A further mental health consultation may be needed.
    c. By emphasising the need for tolerance of and patience with one another's different trauma reactions. Remind parents that families can be the best source of comfort and social support, especially when community systems are temporarily broken down. Even small gestures - such as thank-you notes, sharing resources or toys, or taking special time to listen and hug – can make a big difference to members.
    d. Adolescents may need to be reminded that a period of extra strictness on the part of parents (keeping the teen on a tight rein) is only an expression of the parents' leftover fear from the traumatic event. Encourage the teen to keep in mind, "This, too, shall pass", and be somewhat tolerant of the annoying restriction for a period until things calm down.
2. Assist disaster-affected families to adapt to the circumstances by discussing ways that they can deal with missed milestones (developmental events) and disrupted celebrations. Missed milestones, for example, could be the toddler that was just about ready to undergo toilet training, and now is in a shelter for some weeks with no child toilets. It could be the teen that was just about to get a driver's license, but now the car is swept away by the floods. It could be the adult who was just about to move into a new home, which is now under water, or blown apart by a cyclone.Examples of disrupted celebrations can include events such as getting married, graduating, or having a special birthday party. It is well to find out about such events during the information-gathering phase (refer to section, "Gathering information about needs and current concerns"), and discussions with the family can include whether the event in question can be postponed, relocated, or done differently because of the new circumstances. Sometimes, it is only by shifting goals and expectations that such disruption can be accommodated, as family members come to accept that what is possible now is different from what was possible before.

Don't:

1. Pathologise survivor responses, such as by calling them "symptoms" or "disorders".
2. Encourage survivors to be frightened or alarmed by their own reactions, as they may believe that, "There is something wrong with me" or "I'm weak". Normalise instead.
3. Promise that all their reactions will disappear anytime soon, as doing this may set up unrealistic expectations about recovery.

Linking in with trauma reactions

How able are you to recognise people exhibiting trauma reactions? Even if you are a mental health professional, it is possible that your experience has been geared more towards other aspects of human behaviour, other situations, than trauma. If you feel confident about and comfortable with your ability to recognise trauma reactions for what they are, no further action is needed until you turn up at the disaster scene. But if you do not have experience with this, where in your community might you be able to go to get some "pre-training" in how trauma can manifest in survivors and disaster-affected people? There may be very knowledgeable people, perhaps even some with clinical experience, among the regular disaster mental health responders in your community. Perhaps some community organisations (such as Red Cross) would be able to put you in touch with such individuals for a mentoring/coaching session on this skill. Being skilled in it could make a huge difference in your effectiveness in the field.

Linking survivors with collaborative services

Your goal: To help connect survivor-clients with services they need immediately or in the future

Survivor needs are many, yet those dazed or in the shock of trauma may not be aware of all of the needs that they have, let alone where to link up with services to meet those needs. You can be a helpful link between survivors and available services.

Do:

Link survivors directly with services they need

1. As a psychological first aider, you may have a huge role in linking people with collaborative services through referrals that you make. These may be self-generated (from the survivor themselves), or you may be the one seeing the need for the referral. If at all possible, try to ensure that the connection between the survivor and the service happens successfully (for example: at a shelter or assistance centre, actually walking the person needing the referral over to the appropriate service, or setting up a meeting between the person and the service). Situations which need a referral include:
    a. Acute medical problems, especially those needing immediate attention
    b. Mental health issues, particularly in acutely unwell clients
    c. Clients who need medication to stabilise themselves
    d. Attention to those threatening to harm themselves or others
    e. Survivors who have a pre-existing medical or psychological problem which is getting worse
    f. Cases of observed or suspected abuse or domestic violence
    g. When survivors are exhibiting impaired functioning at least a month post-disaster
    h. When there are concerns about alcohol or substance abuse
    i. When there are significant developmental concerns about children or adolescents
    j. When a survivor or disaster-affected person asks for counselling
2. Where survivors have been connected to agency services before the disaster, it is helpful to provide them linkages to those same agencies again. Some that are active in most communities include:
    a. Schools
    b. Social support services
    c. Medical services
    d. Mental health services
    e. Services for the welfare of children and young people

   f. Support groups, such as those for drug and alcohol recovery, eating disorders, and phobias
3. Ensure that your referral information is correct by:
   a. Summarising the person's needs and concerns as you understand them
   b. Checking that you have understood accurately
   c. Explaining the option of referral to the survivor: what is entailed in it, how it will help the person, and what they can expect
   d. Asking the person for their reaction to the referral process
   e. Trying to make the appointment on the spot, but if that is not possible, give the person written referral information
4. When referring children and adolescents, it is important to:
   a. Try to minimise children's telling and re-telling of the traumatic events to different professionals
   b. Instead, summarise the basic information in writing to give to the professional receiving it
   c. Make sure that follow-up services for families include evaluations of children's adjustment
   d. Make your interactions with children and teens positive, so that they are receptive to future care providers
5. Referrals for older adults may need to include sources such as general practitioners, social support services, senior citizens' centres, and information on ageing programs. Some may benefit from services such as Meals on Wheels, transportation services, or assisted living information.

Don't:

Abandon the survivor-client by failing to provide continuity in helping relationships

While disaster settings do not lend themselves to ongoing care with a single helper, there are some things that you may be able to do to prevent those you have assisted from feeling abandoned or rejected when your two-week (or whatever length) deployment is over. You can help create a sense of ongoing care for survivors if you:

1. Introduce survivors to other relief or disaster mental health workers, so that they know several helpers by name.
2. Give names and contact information for public health, mental health, and other agencies providing post-disaster care.
3. Try to minimise the number of times people must re-explain their situation and tell their story. Try to provide a direct handover to another provider who will be in a position to maintain an ongoing relationship. You can let the new provider know what they need to know about the survivor-client, and – where possible – provide an introduction. (General framework adapted from Brymer et al, 2006)

Linking in with referrals

How knowledgeable and experienced are you with the skill required to successfully do the Psychological First Aid action in question: in this case, making referrals? First consider how confident you are to do it in your own community. If you can do it in your home environment, it is a transferable skill. You might need to learn what services are available in the community where the disaster has happened, but at least you know about how to do it. If you are not comfortable with the process, where could you get some knowledge – or better, experience – with doing it? The more of the eight core actions you have competency in when you step into the disaster scene, the more effective you can be.

Summary

The many individual "dos" and "don'ts" associated with the eight core actions of Psychological First Aid could give the impression that it is complicated and difficult to offer: at least, to get right. And while conditions at the scene of the disaster itself may mean that providing good Psychological First Aid isn't always easy, it is simple. It is at essence the work of making respectful contact with a vulnerable, traumatised person or person(s) and compassionately offering them the practical assistance and emotional support that facilitates their recovery from the trauma.

When people are made safe and comfortable, stabilised, and connected to the supports and services that they need, they can move much more easily from the ranks of "traumatised survivor" to "fully functioning human being." Supported parents can support their children. Supported children can support siblings and other children. Supported people can – and generally want – to support others in need. The level of mental health functioning of the whole community is enhanced. Like the rock dropped into the pond, the ripples can go out a long way.

The next chapter explores what you need to do in order to become that rock dropping yourself into the pond of a disaster field setting.

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Chapter 6

Getting Into The Field

Imagine this: you arrive at the devastated community just hours after the tsunami has rolled in to obliterate buildings, bridges, and of course vehicles for several kilometres inland. You report to the disaster response personnel coordinating the relief effort and ask what you can do to help. The tsunami wave waters have receded, so you are given a terse command to "Go walk around and see who needs help." Feeling uncertain and questioning your usefulness, you begin looking for possible helpees, people who may benefit from the training you have just had in Psychological First Aid.

Suddenly you come upon a disconcerting scene. A woman is sitting on the trunk of an uprooted tree, head in her hands. She seems unaware of what's happening around her. She appears to be shaking. There are several children playing noisily near her, and they seem to be hers, as they occasionally come to stand near her. She does not notice them. Your natural instinct of apprehension is already heightened, but you go into extreme high alert a few seconds later, when you realise that the children are playing very close to a downed electrical wire which is likely to be live. You have now "entered the disaster scene". But what do you do?

It would be nice if disaster mental health response work was such that you as a volunteer could arrive at the scene of your deployment and be warmly welcomed – even hailed as a hero - by those you would soon be helping or working with. After a leisurely tour of "incident command headquarters", you could be shown your spacious, well-appointed private quarters, and encouraged to have a rest, followed by a delicious dinner and a leisurely briefing – maybe even the next day - on the still-unfolding disaster.

Few volunteers report an experience of entering a disaster scene even vaguely like that. As a psychological first aider, you are more likely to be coming into what – at best – might be considered organised chaos. At best, people may be quickly moving around, focused, and with a mission, but without time to explain it to you; in fact, they probably don't even notice you. While you will hopefully be working within a clear and tight chain of command, you may not receive extensive briefing on what to do – or not do. Your sleeping quarters, rather than palatial, may be an army cot in a cramped makeshift tent, with the low-privacy, co-ed ablution blocks at the other end of the volunteers' "camp". Food might be when you can manage a few minutes to eat it. And mental health disaster volunteers have said over and over again that they had to figure out who their "clients" were: whom to assist.

There is general acknowledgement in the field of disaster relief that how you enter the disaster setting will determine much about your success or lack of it in your deployment. But you've taken the training, psyched yourself up for two weeks of seeing humanity at its most vulnerable, and here you are, on the scene. How do you enter it successfully?

The purpose of this chapter is to help you do just that. We look at the core competencies that you should have upon entry into a disaster setting, and encourage you to do a serious self-assessment to find out if you are ready for the challenges of disaster field work. We explore how a disaster environment might differ from your regular practice, and what some of the challenges are that you might face as a member of an interdisciplinary team doing fieldwork. We also include excerpts from reports of disaster mental health responders: their experiences and their advice for others, so you can know what to expect. There is wide agreement that self-care in a disaster deployment is even more important than in "normal" life, so we discuss aspects of stress management and working through personal issues that, unattended to, are likely to decrease your effectiveness in the field.

We can't tell you that it will be profoundly rewarding - that in part may be up to you - but we can report the impact that providing mental health support in the field has had on others. If you like hearing sentences like: "Plan to give everything you bring away; you will want to" but "you will receive more than you ever give" (Rosser, 2008), then read on. You might be ready to offer Psychological First Aid.

Objectives

Upon successful completion of this chapter, you will be able to:

1. Name actions in each of the five core competency areas required to successfully provide Psychological First Aid
2. Specify additional competencies/skills for doing Psychological First Aid work in an Australian context
3. List three differences between "regular" practice and Psychological First Aid fieldwork, and discuss the impact that working in a multidisciplinary team is likely to have on your work
4. Assess whether you are ready to take on all that is entailed in a field deployment
5. Identify at least four recommendations made by other disaster mental health volunteers
6. Formulate a workable stress management plan for while you are in stressful circumstances
7. Describe how you plan to work through personal issues which may affect your fieldwork.

The core competencies of Psychological First Aid

Increasingly, there is common recognition, including by public health and governmental agencies, of what disaster health care workers have known for some time: there is a psychological bill associated with every disaster (U.S. Department of Health and Human Services, 2003). Further, that bill is higher if disaster mental health workers are not trained well, as studies suggest that the level of responder training in mental health crisis intervention is positively related to psychological outcomes for survivors (Stapleton, Lating, Kirkhart, & Everly, 2006).

Given the ultra-importance of crisis responders being appropriately trained in Psychological First Aid, the Center for Public Health Preparedness in the United States was established in 2000 to educate and train the public health workforce to prepare and respond to acts of domestic terrorism, and also other disasters that might threaten the public health and welfare of citizens in the United States. By identifying needed disaster mental health competencies and providing training that reflects them, the Center expected to be better equipped to help communities prepare for and respond to the psychological and psychosocial needs of survivors (Everly et al, 2008).

The competencies developed have come to be widely adopted internationally as a framework for assessing the readiness of those who would deliver Psychological First Aid (Australian Red Cross and Australian Psychological Society, 2010; Brymer et al, 2006).

Disaster Behavioral Health Core Competencies – the seven principles

The framework is based on seven principles that are in accord with the main concepts of Psychological First Aid: namely, that disaster mental health responders will:

1. Agree to perform within their scope of practice
2. Consider the particular needs in the unique context of the incident (for example: what type of disaster it is, the geography, the population it is serving) when applying the competencies
3. Recognise the difference between "regular" practice and fieldwork
4. Be sensitive to cultural and other differences
5. Embrace the principles of Psychological First Aid
6. Recognise the importance of the overriding principle to "do no harm"

7. Recognise the importance of teamwork and adhering to the "incident command system" (Everly et al, 2008).

Disaster Behavioral Health Core Competencies – the five knowledge/skill areas

The framework covers five skill/knowledge areas that successful psychological first aiders should have on entering the field. In order to help you assess how well your knowledge and skill base matches up with the Center's framework, we have converted the core competencies into questions in simple language to help you assess your current competence. The five competency areas relate to whether you:

- Know key terms and concepts related to disaster mental health response
- Have effective communication skills
- Possess skills of needs assessment
- Are able to formulate and implement an action plan
- Know self- and peer-care techniques

Here are the assessment questions:

Key concepts

- Are you able to name the main ways that human beings react when stressed?
- Do you know the phases of community disaster recovery?
- Are you aware of the effects of psychological trauma and disaster-related losses and hardships?
- Can you describe what an "incident command system" is, and the role it plays in guiding a multidisciplinary disaster response team?
- Are you familiar with the main disaster mental health (Psychological First Aid) principles?
- Are you able to employ the chief crisis interventions (core Psychological First Aid actions) with disaster-affected individuals?
- Can you name the responses that should occur before, during, and after a disaster (for example: evacuation before, getting shelters in place during)

Communication skills

1. Are you able to establish rapport with someone you don't know?
2. Do you have active/reflective listening skills?
3. Can you demonstrate effective non-verbal communication?
4. Are you able to put realistic boundaries and expectations in place for your interactions with peers and those you are helping?
5. Do you know how to behave in a culturally competent and developmentally appropriate manner (for example: you know how to address members of the culture you are serving, and you speak more simply to children than to adults)?

Needs assessment

1. Do you know how to gather information in a setting by using various methods, such as observation, self-report, reports from others, and other means?
2. Can you identify if a person has any immediate medical needs?
3. Can you identify where there are basic human needs (i.e., for food, clothing, shelter) to be met?
4. Can you identify social and emotional needs?
5. How well are you able to determine someone's level of functionality (that is, their ability to care for themselves and others and to follow medical advice and safety orders)?
6. How well are you able to recognise mild psychological and behavioural distress reactions and distinguish these from potentially incapacitating reactions (that would require more intensive mental health care)?
7. How well are you able to put together the assessment information you have gained?

Action planning

1. Can you develop an action plan, including being able to:
    a. Identify available resources (e.g., food, shelter, medical, transportation, crisis intervention services, local counselling services, financial resources)?
    b. Identify appropriate stress management interventions?
    c. Formulate the plan?
2. Can you initiate an action plan, including but not limited to:
    a. Providing appropriate stress management, where needed
    b. Connecting to available resources (as in 1a)?
    c. Connecting to natural support systems (such as family, friends, co-workers, spiritual supports)
    d. Implementing other interventions as needed?
3. How well are you able to evaluate the effectiveness of an action plan, considering changes in situation or disaster phase through methods such as observation, self-report, other reports, and other assessments?
4. How willing/able are you to revise any action plan as needed (for example, as you track progress and outcomes)?

Peer-/self-care

1. Can you describe peer-care techniques?
2. How well-versed are you in self-care techniques, such as: stress management; journaling; communication with "significant others" (partner, children); getting proper exercise, nutrition, programmed "down time", and sufficient quality sleep?
3. Which, if any, organisational interventions are you aware of to reduce job stress (for example: organisational briefings, adjustment of work shifts, job rotations, location rotations, effective and empathic leadership, work/rest/nourishment cycles, and support services? (Competencies, undated).

The competencies: where do you stand?

The authors of the framework noted that it could be used, not only in developing training programs for providers of Psychological First Aid, but also to select individuals for deployment to disaster sites. Given that, we ask: how do you stack up in answering the questions? This course covers the "key concepts" of the first set of competencies, so we wouldn't expect you to be able to say "yes" to all of those until you have successfully completed the course. You are likely to have known the areas of "communication skills" and "peer-/self-care" before starting this course. The "needs assessment" and "action planning" competency areas are in-between, in that you may very well have some general skills in those areas, which can transfer to a disaster setting once you have studied what tends to be needed specifically in disaster mental health response (and the course covers some of that).

Why are we commenting on this? It is important for you not to lose heart, or start believing that you have nothing to offer this field, if you had a number of "no, not yet" responses above. And you may have noticed that a number of the key competency areas in the framework are eminently learnable. That is, you can learn to do needs assessment in a disaster setting, if you don't already know it. It is more difficult to train someone to take care of themselves, or to communicate with warmth and empathy, if they have had years of not doing that. If you are drawn to doing this work, please hang in there; you undoubtedly have many skills to offer it. That said, we want to ask you to assess yourself on yet more dimensions.

Assessing your readiness for fieldwork

It is one (important) thing to possess the professional and interpersonal competencies to enable you to successfully deploy to a disaster. It is quite another to be ready in terms of personal issues: considerations related to your personal circumstances and development, your family needs, your health, and what your "day job" will allow. This group of considerations may be more changeable than the competency framework, in that a potential psychological first aider might have, say, young children at home or have just undergone surgery one year and be unable to deploy, yet a year or two later, the picture might look very different. Because disaster mental health work is so demanding, it is crucial for you to be free of other major concerns at the time that you enter a disaster scene. Have a look at these questions, adapted from the Psychological First Aid Field Operations Guide (Brymer et al, 2006). They constitute an important part of your pre-deployment self-assessment.

Personal Considerations

How comfortable are you with the following situations typically encountered by those providing Psychological First Aid?

- You might need to work with individuals who are experiencing intense distress and extreme reactions. These might include screaming, hysterical crying, anger, or withdrawal
- You will undoubtedly be working in a very different setting than your normal one, even if you are using the same skills you use in your "regular" life
- The disaster environment is likely to be unpredictable and chaotic
- You may have come prepared to comfort and console people, but find that you are asked instead to sweep floors, clean toilets, and hand out food
- You may need to work with very little supervision
- You may strike a supervisor who micro-manages you
- You may find yourself working with people of a very different cultural, racial, ethnic, or religious group than your own.
- You may be used to adults, and suddenly find you need to translate what you know to the children you are now working with
- The environment you are in may expose you to unknown risk or harm
- You may be called upon to support individuals who are not receptive to receiving your help
- You may need to work with a diverse group of professionals, each of whom has a different interpersonal style to yours

Health Considerations

How allowing is your health of your desire to do disaster work? Assess both your physical and emotional health status in terms of any factor or condition that might negatively impact on your ability to do demanding work in long shifts. Ask yourself if you have had or currently have:

- Recent surgeries or medical treatments
- Any recent mental un-wellness, or psychological health challenges
- Major life changes or losses within the past year
- Traumatic life events or early losses
- Dietary restrictions that would take your focus off your work
- The capacity to endure physically exhausting conditions and long periods of activity
- Enough medication available for the total length of your assignment plus some extra days

Family Considerations

Assess how well your family will cope with your providing Psychological First Aid in a disaster setting:

- Is your family prepared for you to be gone for days or even weeks?
- How willing is your family for you to work in environments where the risk of harm or exposure to harm is not fully known?

- How well will your support systems (family/friends) take on your family responsibilities and duties while you are away or working long hours?
- Do you have any unresolved family or relationship issues that will make it challenging for you to focus on disaster-related duties?
- How strong and supportive is the environment to which you will return after your disaster assignment?

Work Considerations

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

- How supportive is your employer of your interest and participation in Psychological First Aid?
- Will your employer allow you leave from your job?
- Will your employer require you either to utilise holiday leave or to take "leave without pay" in order to respond as a disaster mental health worker?
- How flexible is your work position? That is, will it allow you to respond to a disaster assignment within 24-48 hours of being contacted?
- How supportive will your co-workers be of your absence and how supportive is the environment they will provide upon your return?

Linking in with yourself

Where are things at for you now: personally, health-wise, and in terms of your work? If you are mostly clear of the kinds of obstacles to effective service described above, you may be close to being able to say, "Yes, I'll go!" Examine each category, and choose the obstacle in each that seems to be most "in the road" of signing up for deployment. How amenable are these challenges to being overcome? For example, right now you might be in the middle of a crucial work project, but in six months you work may be much more flexible. On the other hand, if you have heavy commitments, say, caring for a family member who is chronically unwell, your situation may not shift for some time. Challenge yourself to find at least one obstacle that you could work through now, as a means of readying yourself for deployment to a disaster field setting.

Psychological First Aid in an Australian context

While the above competencies, skills, and personal readiness factors are appropriate assessment tools for any disaster situation, the Australian Red Cross lists additional competencies for successful delivery of Psychological First Aid in an Australian setting. Acknowledging the importance of knowing about the core skills and action principles, and also the areas of competency listed above, the Australian Red Cross further specifies that individuals offering disaster mental health in Australia should have:

- An understanding of the disaster context
- The ability to stay calm and focused
- A communication style characterised by warmth, empathy, and compassion for others
- Flexibility
- Problem-solving skills (Australian Red Cross and Australian Psychological Society, 2010).

Training in Psychological First Aid

The Red Cross discusses the question of training, and offers recommendations about how much training is needed for various roles through which psychosocial support might be offered, post-incident.

For the general workforce of trained responders

In order to provide a competent disaster workforce, the Red Cross strongly advises that an introduction to Psychological First Aid be a standard part of the training and briefing of trained responders working in an emergency in a variety of capacities. They recommend that all personnel be given at least a half-day course introducing them to the principles of Psychological First Aid. Such courses enable responders to comfort and calm survivors, to "do no harm", and to look after themselves and their peers.

The Red Cross notes that some organisations even provide such training for all staff, whether trained to be first responders or not, in case there is ever a mass incident at the workplace.

For responders whose specific task is providing psychosocial support. More advanced training in Psychological First aid is recommended for people who are working, or intend working, in an emergency situation with the specific task of meeting people's needs for psychosocial support. The Red Cross suggests that psychological first aiders undergo at least one day of training, with the objective of gaining:

- An introduction to Psychological First Aid, similar to what general disaster responders need (as above)
- Detailed information about how to apply Psychological First Aid in the specific context in which they are or will be working.

For the public

As well as training people who are working in disasters in how to deliver Psychological First Aid, the Red Cross believes that the general public should learn these basic skills. Some disaster mental health experts maintain that the effect of Psychological First Aid is positively correlated with the extent to which it has spread throughout the population (Jacobs, 2010). The aim is to deliver Psychological First Aid training widely throughout communities that are vulnerable to disasters. The core components of community-based Psychological First Aid training include skills like:

- understanding traumatic stress
- active listening skills
- how to make referrals and when
- self-care (Jacobs, 2010).

Courses like the present one are integral to raising both awareness and skills levels for all of the groups named above. If you are a trained mental health worker already, the next chapter may be a further eye-opener. We look at how disaster mental health responding differs from a practitioner's "regular", non-disaster practice.

The challenges of Psychological First Aid in a field setting

In Chapter Two we described in a general way the difference between the ordered, structured setting of a typical mental health worker's office, and the highly charged, chaotic atmosphere of a disaster. Consider these contrasting situations:

1. **Situation One:** the office work. You finish a session and go out to your waiting room to bring the next client in. He is a quiet man of about 28 having a hard time with a life transition. He has a girlfriend and wants to move the relationship forward, but is frightened about the idea of marriage. Together, you spend time with him looking into the question of "What's behind the fear of marriage?" and unearth some early experiences that could be contributing to his discomfort. He feels happy to have gained the insights, and wants to know how he can apply them in his present life. You jointly generate some solutions that he agrees to try before the next session. He happily pays the fee and departs, with an appointment to return the following week at the same time. You feel good about your ability to help clients get a new perspective and solve their problems.

2. **Situation Two:** the disaster work. In walking around the small community hardest hit by the cyclone yesterday, you come upon a similar-aged man. He is just as quiet as the client who came into your office to work on his relationship, but this man's "relational" woes are quite different. He was at work when the cyclone struck, and could not get home in time to be with his wife and two small children. Their community's power had gone out even before the cyclone made landfall, so authorities were not able to warn everyone who needed to evacuate. Now he is at the site of their former home, a mere pile of rubble. He spent all night searching for his family, but they appear not to have turned up to any of the evacuation centres. Nor can any trace of them be seen here at their former residence. Bowed with grief and fearing the worst, he is numb and withdrawn, with hollow eyes. You make the decision to approach, and engage with him as a potential client, although you are not at all sure what difference your presence could make to him.

Here are two very different situations, two very different realities. They typify the contrast between mental health helping in an office or practice setting, and that of a disaster. Beyond the starkly contrasting differences in physical environment, a whole host of other differences awaits the disaster mental health volunteer. We describe issues of scope of practice, "turf battles", interpersonal boundaries (including dual relationships), compassion fatigue, and cultural competence.

Scope of practice differences

The nature of disaster response teams is that they are interdisciplinary, and this includes the lay people, such as teachers, members of the clergy, and sometimes school administrators, who are not professionally trained as mental health helpers, but who are instrumental in supporting relief efforts in the early aftermath of an emergency or disaster. Because the various volunteers – each with a unique life experience and area of expertise - are coming into the scene from such different professional understandings, it is essential for team members to be operating from a common understanding in terms of the individual and group interventions that are part of crisis response and management. They can only get that common understanding through specific, common training. Training such as that provided by the Green Cross Foundation or the International Critical Incident Stress Foundation (ICISF) can be helpful in cutting across disciplinary distinctions between the professional and the lay person, thus melding the team (Green Cross Foundation, 2004; ICISF, 2004), but it engenders more issues of scope of practice to deal with.

The consensus in emerging literature regarding transdisciplinary teamwork in health care is that members of trauma teams must work together to identify and negotiate areas of cross-disciplinary flexibility and overlap in roles. Accordingly, the overlap of their roles is relatively broad as compared with everyday practice. Marriage and family therapist Mendenhall, for example, noted that he had helped stock food shelves and emergency supplies, assisted medical personnel with preparing vaccinations, and cleaned wounds. He had helped move rubble and raise tents where families' homes used to be. He spoke of both doctors and lay people who did the same. A veteran responder involved in the September 11, 2001 attacks on New York City, the Indonesian tsunami of 2004, and Hurricanes Katrina and Rita in the United States, Mendenhall explained that, in the Louisiana disasters, they called that "being fluid." Flexibility was so important to the teams on which he served that sticking to the parameters of one's normal practice was explicitly discussed as being counterproductive. So doctors offered emotional support, psychologists drew vaccinations, and everyone stocked emergency supplies in the shelters (Mendenhall, 2006). Ultimately, while practitioners need to be careful not to extend so far beyond their scope of practice that they might harm someone, the watchword in carrying out successful fieldwork is flexibility.

"Turf battles"

Have you ever worked in an organisation where one or more members jealously guarded their little patch of expertise, refusing to let other workers touch projects that were in the member's acknowledged area of understanding? In fact, some professionals would claim that such non-collaborative in-fighting is par for the course, business as usual, in organisations where there are multiple practitioners of the same or similar sorts. It does not belong – and some would say, does not occur anywhere near as frequently – in disaster settings, where the survivors being served could not

care less about a practitioner's publication record, how many letters are after his or her name, or how well-respected the person is in his or her chosen field. What the "clients" in the aftermath of a disaster care about is whether – and how - the psychological first aider cares for them, and helps them to meet the many needs that they suddenly have.

Through offering our help after the disaster, we can remind ourselves as volunteers why we got into a helping business in the first place: to ease the suffering of people who are hurting and to empower their growth and build their capacity in the face of hardship. There are many ways in which we can do this in a collaborative and harmonious manner with our fellow volunteers (North, Weaver, & Hong, 2001). It is heart-warming to note that, for all the huge challenges that exist in typical fieldwork settings, this area at least may be less problematic for the incoming professional.

Interpersonal boundaries and those unavoidable dual relationships

In the disaster relief scene we posed at the beginning, we placed you, the volunteer, in an army cot in a makeshift tent for accommodation. Let us now add more layers of challenge. The tent may or may not have a curtain hanging down to separate you from the person or people who are on the scene as your supervisor(s), or the people that you report to, or even the opposite sex. The shower may be in another building, across the street (Haskett et al, 2008). You may be required to attend debriefing meetings with such people – supervisors and managers – in which personal struggles, reactivity, and emotional responses to trauma work are shared and processed. You may become friends with someone on a team and be faced with whether or not it is appropriate to administer medications for one another. And perhaps worse, you may wonder where you should draw the line between performing therapy with each other and simply being supportive in response to normal reactions to the intensity of fieldwork's content and processes.

Veteran disaster responders (Mendenhall, 2006; Haskett et al, 2008) acknowledge that they are not aware of literature on how to deal with these sorts of boundary and personal relationship challenges, but suggest that the most effective method may be to simply hold direct and frank discussions with colleagues, supervisors, and students, in the understanding that such challenges in the context of fieldwork require constant diligence and attention in order to keep responders psychologically safe, and to make sure that no ethical violations are committed. Professional mental health responders may provide the service for one another of observing when a colleague is experiencing a breakdown beyond what normal debriefing can address, and supervisors in field settings are on active alert for team members who may need further consultation and assistance, so that in such cases, psychological first aiders can receive the immediate mental health services that they need (Mendenhall, 2006).

Compassion fatigue

The intense and gruelling nature of fieldwork means that disaster mental health volunteers are at far greater risk than normal of acquiring mental health problems. When a person's physical, mental-emotional, and spiritual resources begin to be depleted, they can exhibit a wide range of symptoms, generally regarded as being part of compassion fatigue.

The physical manifestations of compassion fatigue can include such symptoms as:

- a chronic sense of exhaustion and fatigue
- insomnia
- headaches
- stomach aches
- lack of appetite
- physical agitation or retardation
- frequent bouts of sickness (for example, colds or sore throats).

Psychologically, sufferers of compassion fatigue can exhibit symptoms such as:

- feeling irritable
- being overwhelmed by the volume and content of the work
- experiencing a decrease in the empathy they feel for others

- feeling numb to patients' and families' pain
- coming to be cynical about patients' and families' ability to change
- perceiving the people they are trying to help as being responsible for many of their own problems
- feeling scattered, with difficulty meeting their professional and personal obligations (for example, doing paperwork and calling home, respectively).

Obviously, mental health professionals can experience the above symptoms working from within the calmest-looking of offices, even working exclusively with "the worried well": meaning, no deeply disordered or traumatised individuals. It's just that the intensity of field settings predisposes helpers to compassion fatigue and similar risks. If you are contemplating disaster fieldwork, you will be pleased to hear that supervisors generally are highly cued to look out for team members suffering from burnout of this sort, and a number of veteran volunteers have stated that generally supervisors and those doing rosters attempt to give volunteers no more than three to five days on, with one or two for rest (this doesn't always happen). Supervisors also encourage volunteers to take time for self-care, while acknowledging how long the shifts can be (Mendenhall, 2006; Haskett et al, 2008).

Cultural competence

In terms of cultural competence, the differences between "regular practice" and field work may be subtle but impactful. A client needing mental health support from, say, a counsellor or psychologist at home in his community in "regular life" would ordinarily (except, perhaps in the case of very small or isolated communities) be able to choose a therapist or helper which more closely matches his ethnicity, religious outlook, or even preferred school of psychology. In the somewhat uncommon situation of one or both sensing a serious inability to build a proper therapeutic alliance, that client can either be referred on to a more appropriate person, or in some cases, may choose to seek one out himself. In disaster relief, that is all turned on its head, as the survivor – mired in grief, loss, and possible separation as a result of the disaster - may not even know that there is psychosocial support available. The psychological first aider seeking out "clients" will probably know nothing about a given survivor or disaster-affected person before approaching them, and even if the two are vastly different in terms of everything from language, culture, and religion to personal paradigm, there may not be a lot of other choice in who can support the person.

Thus, it is incumbent on the psychological first aider, first of all, to find out whatever he or she can about the language, culture, and social context of the community where the disaster has struck. As noted in Chapter Three, it is supremely important, especially in ethnically diverse regions, to possess some cultural competence (Dudley-Grant, Mendez, & Zinn, 2000). But it is not enough to have read some textbooks about the area, be comfortable working with an interpreter, and generally be an open, accepting person. No, although those things help to build rapport and credibility with the population being served, the essential ingredient for incoming psychological first aiders is to genuinely expect to collaborate – equal to equal – as the volunteer offers the disaster-affected resources and knowledge of how to do Psychological First Aid, and accepts from that same population the lived experience and understanding of the community that the locals have.

Part and parcel of that collaboration is the psychological first aider's capacity to engage local members of the community in the organisation and design of outreach efforts (Doherty & Mendenhall, 2006; Minkler & Wallerstein, 2003). Meanwhile local community members educate trauma experts about their cultural, ethnic, and religious belief systems; social structures; and local resources. And everyone works together to respond to the community's needs (Mendenhall, 2006).

Linking in with yourself

Review the categories of office-field difference above. Whether or not you are a mental health professional, identify for yourself which of the differences seems the most challenging for a first-time psychological first aider. What is it about this aspect of field work that seems so daunting? An emergency room doctor, for instance, wanted to go serve in a disaster zone, but was worried about being asked to do something out of his ken, harming the recipient of his assistance, and possibly being sued later on. This is understandable given the hostile medico-legal environment in which many doctors in the Western world practice these days. It constitutes a challenge, however, for highly ethical practitioners who would like to serve but take the issue of "scope of practice" seriously. What might you be able to do – if only a small step – to move beyond concern in this area? The doctor was able to review typical actions that doctors in a disaster setting would be asked to do, and listed for himself a few tasks that he realised he would be highly uncomfortable to perform. Reviewing his long list of "ok services to render" enabled him to say yes to a deployment.

Being on the frontline: the experiences of veteran psychological first aiders

We've communicated much already about the rigours of doing disaster relief work in a field setting: the intensity and chaos, the long hours, and the unrelenting and consummately demanding nature of the work. Is that all there is? If so, why would anyone volunteer to go help out anywhere? Yet many disaster mental health responders are seasoned psychological first aiders, having served in multiple disasters. If Psychological First Aid is so unrewarding, why have they signed up again and again? We look now into the experiences that some mental health professionals have had, and what advice they may have for those readying themselves for work "on the frontline" of a disaster.

Mental health disaster relief work: the experience

For one of its 2008 editions, the journal, Professional Psychology: Research and Practice, issued an open call for submissions from psychologists who had had a deployment in the aftermath of Hurricane Katrina. We draw from the articles of those who offered their professional and personal responses to the extraordinary impact of the disaster. The psychologists describe a variety of roles, actions, involvement, psychological preparation, and reactions they had during the disaster and in the months following.

The training they did or didn't get While all the psychologists commented on the need to find out what they could about the disaster, and also about how the areas of New Orleans and Mississippi were before the disaster, only two parties – a group of four from North Carolina and Michael Levy from Massachusetts – stated that they had had specific, formal training before deploying. For the North Carolina group, the focus of their training was "information on providing mental health services in large group settings." They were given a description of the disaster area, told about possible hardships they would encounter (such as blistering heat and poor air quality), given information about working with diverse populations with sensitivity and confidentiality, and told to do self-care and to care for their personal safety. They were also told to travel light, with duffel bags and the like (Haskett et al, 2008).

Levy reports receiving a one-day abbreviated training course from the Red Cross about the Red Cross and about working in disaster areas (Levy, 2008).

Meanwhile, Simon Rosser, from Minnesota, had just 24 hours' notice before deployment and was only able to review literature. He studied evidence-based approaches to Psychological First Aid, counselling a traumatised person, reminders on how assessment and intervention can vary according to the disaster, and tips on what to avoid. What he wasn't told was how to assess a community's mental health, although part of his brief was to create a sustainable method for delivery of evacuee primary health care for people who had been displaced for some time (Rosser, 2008).

Joy Osofsky, who did not receive training before deploying, lived and worked in New Orleans and had 20 years' experience in working with trauma before her stint (Osofsky, 2008).

As part of preparation, if not formal training, Rosser was advised to take along a "bum bag" with such items as a small notebook, his psychologist's licence, his passport, a pocket DSM – IV (the Diagnostic and Statistics Manual used by health professionals to make diagnoses), a mobile phone, a list of team members' mobile phones, and pictures of his family. He found the items very useful (Rosser, 2008).

The scenes they encountered While the psychologists entered the "after-Katrina" scene at different times, all commented on how it appeared to be like a war zone. Osofsky commented, upon being taken to where their command centre would operate from, that the media had covered well the destruction from the massive flooding, but hardly commented on all the wind damage from the hurricane:

"We saw not only huge signs blown down, but also sides of buildings blown away. The flooding and destruction from the winds of Hurricane Katrina made parts of the New Orleans metropolitan area look like a war zone. In the city, there were no lights, many trees were down across streets, buildings had collapsed in the street, street signs were down, and there was an overwhelming feeling of destruction, even in the areas of the city that were not flooded. Many streets were still under water". (Osofsky, 2008, p 14)

The North Carolina group commented on conditions weeks after the hurricane at one of the shelters where one of their contingent, Kennard Nears, was assigned:

"There were 20–40 homeless families living at the shelter. Some of these families consisted of three or four generations. Weeks into the disaster, clients still slept on cots and the only option for personal hygiene was gymnasium showers that were non-functional at times. Many shelter residents were afraid to take a shower because security and privacy were minimal. Nears was able to spend more time with each client in this setting than in many other settings. In addition to brief crisis counseling, he also addressed grief and trauma symptoms. Children were of particular concern; some of them had been in the shelter for nearly 8 weeks. Their homes and most of their belongings had been destroyed. Many had lost parents and/or other family members. They were out of touch with friends, and their routines had been terribly disrupted." (Haskett et al, 2008, p 95).

The tasks they were assigned Interestingly, although the psychologists went in with different assignments according to their backgrounds and experience, they all reported having at least three "client" groups: the survivors and disaster-affected people that they would encounter; fellow members of the disaster mental health teams; and the other relief workers, such as shelter administrators, rescue workers, and local helpers (police and fire fighters, for example). Eighty per cent of this last group had also lost their homes (Osofsky, 2008).

Rosser (2008) was tasked with providing primary health care, especially mental health care; conducting mass vaccination programmes, staffing a special needs shelter, and creating a method for delivering health care to people who had been displaced a long time. The North Carolina team was assigned part-time to a "client service centre", where clients waited four to six hours in the hot sun to see if they were eligible for financial aid. The team often engaged with people out in the parking lot, where the wait would begin, offering cold drinks, food, and comfort. The service centre would see over 700 people each day. They also found themselves on ERVs (Emergency Response Vehicles), looking for survivors in neighbourhoods where any remaining residents had to hide from authorities, as their homes had been deemed unsafe (Haskett et al, 2008).

Both Osofsky and Rosser developed instruments to screen for trauma symptoms and Acute Stress Disorder or Post Traumatic Stress Disorder (PTSD); Osofky's measure was developed to help traumatised children. In addition, she, together with her team, did individual and group work with children, set up child care centres for young children living on the cruise ships (which became home to the many displaced responders), and provided respite for parents.

Levy, when not supporting shelter residents or other mental health team members or being on call for psychiatric emergencies, helped to rebuild the mental health infrastructure of one community. He did this first by learning what mental health services still were available or had reopened, and later by informing other community members of these resources: members who in their work encountered individuals who needed mental health care. Linkages and lines of communication were formed in this way so that referrals could be made. (Levy, 2008)

The Psychological First Aid that they did No matter what the specific wording of their assignments was, however, all the psychologists stated – no, emphasised – that:

1. They spent a good portion of the time doing activities that they did not originally consider to be "psychologist work" – tasks such as handing out food, cleaning toilets, setting up shelters, and helping residents complete forms in order to receive relief funding;
2. No matter what else they did or were assigned to do, the most important thing that they did – and the thing that they got the most heartfelt thank-yous from survivors, responders, and fellow mental health staff workers for doing – was listening to people. They all related vignettes of these experiences

Levy, for example, reflected on the importance of helping people to feel understood through active listening:

"When working with the victims of Katrina, I found that many people wanted and needed to tell their story. All one needed to say was, "How did you make out with Katrina?"… and people would pour out their stories. It was as if they could not tell their story enough, and they wanted to communicate it to someone new and who had not been involved. I saw how beneficial it was to listen and occasionally reflect back their feelings and experiences. And this would happen in coffee shops, restaurants, or stores. I am reminded of one woman I met at a drugstore. After telling her story, she told me not to leave and then ran to her car to get pictures of her destroyed home to show me. She so much wanted and needed to let me into her world, and she thanked me so much for listening. And this is one of many examples…

When this was taking place, I initially thought nothing of it. This was simply something I did and something that I was used to doing. I was just talking with people and hopefully making them feel better and, in some small way, helping them in their healing process. But then I had an epiphany: in fact, not just anyone can truly listen objectively and reflect back to a person his or her inner experience. So often, people allow their own experiences to color what the other person is saying, they miss the mark, and the person does not feel understood and known.… Reflective listening is a skill and is one of the most important skills to have if one is going to conduct quality disaster mental health services." (Levy, 2008, p 32)

The team from North Carolina likewise reported the importance of the listening component of their broader service of Psychological First Aid:

"Listening was our primary method of helping clients. Through actively listening, we were normalizing and validating feelings. Often the stories clients told included life histories, as they placed the disaster in the context of their lives. Most clients we saw in the Gulf Coast region seemed to want to share their experience. From merchants in shops in the French Quarter to custodial staff at our hotels, all had emotional stories to share. In addition to allowing clients to share their experiences, we had to be open to clients' silence. Often we simply held clients' hands and let them cry. We tried to identify strengths and coping strategies in the personal tales of tragedy clients shared with us. We then discussed those with the clients with the hope that they would feel more empowered." (Haskett et al, p 97)

Rosser reported his team receiving thanks both from individuals and at the level of community organisation as well. He was told by a community organiser:

"Say in your report, that after I surveyed all the people you all served, they told me that they were so impressed with the quality of treatment they received. They said they loved the way all of you listened to them and talked to them and took time with them. That is something they do not get when being treated in New Orleans or in Louisiana. The treatment you all provided was a vital part of their survival and recovery." (Rosser, 2008, p 40)

Mental health disaster relief work: the lessons learned

As heartful as some of the stories of the psychologists' experiences were, the lessons they reported learning from their disaster deployment were even more so. And despite the different personalities, assignments, and disaster phases during which they were deployed, there were remarkable similarities in what they learned. Here is a summary, supported by anecdotes.

Go as part of the team and know its mission As discussed in Chapter Three, Rosser (2008) expressed gratefulness that he had been part of an organised mission. Without that, he said, he would not have been as rapidly deployed, he would not have had as much access to needed resources (including supervision and capacity to refer), and he would have encountered much greater frustration. He strongly recommended getting clear on both the mission of the organisation through which one deploys, and also the specific task designations one is given.

Expect the unexpected and be flexible Most of the reports contained advice in this direction, which speaks to the unpredictable, intense, and - by nature - chaotic reality of disaster aftermaths. The North Carolina psychologists reported that they had daily changes to their assignments; in fact, it was sometimes twice daily. In terms of the "mess" on the ground, they reported that directions to locations were difficult to follow because road signs were missing and many roads could not be travelled. One of their team, Haskett, was given the following instructions to find an assignment location: "When you get to the boat in the tree, turn left." (Haskett, 2008, p 98) In order to reduce frustration and maintain patience in such circumstances, they needed to use their best problem-solving and coping skills.

Rosser also found problem-solving skills to be critical, and stressed how "out-of-the-box" thinking was helpful on more than one occasion. For instance, he encountered reluctance with some clients to accept his help because, now without any material means, they did not wish to be in the dependent position of having accepted help and being unable to pay for it. He knew that he needed to find a way of creating a more equal, non-dependent relationship, yet in working with people who had lost everything, that could be challenging. He reported noticing how religiously-oriented many were (commented on also by the North Carolina team; the dominant traditions were either French-Catholic or Evangelical), and so had many conversations like the following:

Rosser reported his team receiving thanks both from individuals and at the level of community organisation as well. He was told by a community organiser:

"I see you have your scapula. ('Oh yes, I never take it off. It saw me through.') You know, tonight when you go to bed, would you mind partnering with our team by keeping us in your prayers? Please, say an Our Father or Hail Mary for us. It would mean a lot." (Rosser, 2008, p 40) From a psychological perspective, the person being asked to pray was being given an achievable task, one which framed their role as part of the response team, and thus empowered them. It also allowed them to have the sense that they had "paid" for their treatment, thus keeping the relationship reciprocal.

Broaden your perspective on what being a mental health professional means Levy, Rosser, and the North Carolina group all shared how they came only with expectations about what they might be doing, but no real "psychologist" job description. All ended up doing quite different tasks from what they expected, and some even questioned how useful their services were. Rosser described how he ended up needing to do all of the following:

- planning and supervising mental health services
- providing direct clinical care
- providing remedial clinical services
- providing para-clinical (that is, listening) services to those directly and indirectly affected
- supplementing surviving psychological services that were overstretched, damaged, no longer, or never in existence;
- assessing the psychological impact of the disaster and helping health providers to note and understand changing patterns
- providing psychological support services to other primary disaster responders.

In setting up services, Rosser found that it was critical to consider issues of sustainability and not to promise anything that could not be delivered. He advised disaster mental health volunteers to "think long-term and act short-term." (Rosser, 2008, p 42).

Levy acknowledged that, not having served in a disaster before Katrina, he "naively" expected to be doing typical "psychologist" jobs. He found that, although those were among his daily tasks, more often than not, that was not what he did. He came to understand, however, that that did not mean that he had not been "therapeutic":

"I began offering people food or a cold drink and simply engaging them in conversation about their concerns. Without offering them "therapy," I assumed the role of a supportive listener and, through indirect ways, was there for them to talk with...I came to see that being therapeutic was something that I could do all of the time and was a way of being... And by therapeutic, I mean allowing people to express whatever they wanted to talk about, giving them the opportunity and freedom to take up the space, letting them know that I understood their pain, and simply being a supportive listener." (Levy, 2008, p 33)

The North Carolina team, all of whom served some time at client service centres, summarised their daily rhythms:

"In addition to being the primary providers of mental health care, we served in various capacities within the client service center. For example, it was important to help with daily labor tasks, such as unloading trucks, setting up, and cleaning the facility. Our work started in parking lots, where clients either received tickets that had the date and time they were to return to the center for services or stood in line to wait for services. Waiting took place first in the hot sun, then in a non- or poorly air conditioned building or under tents. It took clients 4–6 hr to find out whether they were eligible for services; most of that time was spent in line. Mental health volunteers worked the lines talking with clients, answering questions, giving toys to children, and providing drinks and snacks. We assisted clients in completing the required forms and even activated debit cards that provided clients with financial assistance. Within our varied roles, we had the opportunity to assess clients' mental health needs, provide information, validate their experiences, process feelings, and offer support and encouragement. By being involved in all aspects of the client service center, we were readily accessible to clients, to relief workers who needed assistance with clients, or to volunteers for their own personal needs. (Haskett et al, 2008, pp 94 – 95).

Do what you can do: do not be overwhelmed, but do not be over your limits In apparent contradiction to the previous advice, disaster mental health volunteers often express concern that the resources they bring will be woefully inadequate for the extreme level of need post-catastrophe. Moreover, there is the fear that, in trying to be of assistance in a situation where normal systems for helping have been wiped out, they will be called upon to act beyond their scope of competence, and thereby cause harm. So for many it is a dance of being available and flexible, taking on often mundane tasks that they would not have called "psychologist tasks", but counterbalanced by being willing to consider doing some things that are at the deep end of mental health helping, that they previously would have referred, except that in the situation, there was no one to refer to. The Katrina volunteers were no different.

Both Levy and Haskett et all expressed the initial sense of overwhelm, and then frustration at not being able to make appropriate referrals. Levy commented that the devastation that Katrina had brought was hard to fully imagine without seeing the actual destruction. He noted that viewing pictures on television, reading stories, or hearing news clips could provide only a glimpse of what truly took place. Thus, when seeing the destruction the storm had caused, it was easy to get overwhelmed, with the related feeling of powerlessness and futility to truly make any beneficial impact. Levy knew that he had a limited deployment, and so found himself asking what, with only with only two weeks, he could really do (Levy, 2008).

Similarly, the North Carolina team talked about having to face their own apprehension and lack of confidence in being able to meet the many needs generated by the hurricane. Yet when they arrived "in the field", they realised that there was no time for the luxury of overwhelm. They needed to get right into the work, and as they were there for only two weeks, they quickly needed to become experts (Haskett et al, 2008). Yet they were "experts" in a no-longer-functioning state:

"One of the biggest challenges to our work was that systems of mental health care and social services in the Gulf Coast region had been obliterated. Also unavailable were housing, transportation, sanitation, and good communication about the changing services that were available. Although medical professionals made heroic efforts to provide care during and after the hurricane (Frank, 2005), medical care was essentially non-existent for all but immediately life-threatening situations (see Rosenbaum, 2006). Thus, we learned to live with discouragement stemming from our inability to make referrals to needed services for so many clients with serious needs. We learned to find satisfaction in simple accomplishments like providing food to hungry clients, connecting someone with services they needed, playing ball with children while they waited for their parents, and giving clients the correct answers to their questions." (Haskett et al, 2008, p 98)

Rosser summarised the challenge that many health professionals – even those who are comfortable with their "normal" skills - face in a post-disaster situation such as Katrina:

"Figuring out where and how to spend one's energy involved more than thinking about one's strengths and talents. We considered multiple models, including a specialist team of mental health workers, rotating persons across teams, and so forth. Ethically, when one is the only mental health worker in the field and only there perhaps for part of a day, the first challenge was establishing what was to be prioritized. By the time we arrived, what mental health services that had existed were stretched to the limit or broken. Referrals anywhere were tenuous. Planning how to

be helpful, and especially how not to unintentionally burden a stressed system, was critical. I experienced an ethical dilemma between two tensions: on the one hand, not practicing outside one's expertise; on the other, not refusing care to those in critical need as the only mental health professional in a particular shelter, town, or deployment. (Rosser, 2008, p 42)

Finally, Rosser suggested that, in a disaster, everyone is a counsellor, in the sense that, because the mental health concerns presented in the post-Katrina environment were among both the most serious and also the most common, everyone – including doctors, nurses, immunisers and others – needed to use the short four-question assessment for mental health issues that Rosser developed, and let the specific mental health volunteers know if people needed extra assistance (Rosser, 2008).

Understand the reciprocal importance of community and individual to each other Levy observed that, where before Katrina he had personally not felt that connected to his home community, he began to see the immense importance of a community to its members, and also, the critical importance of individuals giving back to their communities. He noted how experts in mental health social support have recognised the huge value of connection to and being embedded within a support system, both for mental health and for overall quality of life. Being in Mississippi and witnessing the destruction of the social network and infrastructure that occurred highlighted for Levy just how integral the community is to its members for both instrumental and emotional support. He felt convinced that people could not have begun the process of rebuilding their lives without it.

He observed, however, that, whereas the community's help was crucial for the individual, the opposite situation – the individual giving back to the community – was also necessary for the community, and ego-strengthening for the individual. He observed how residents of the area, nearly all affected themselves, helped out their friends and neighbours. The sheer magnitude of the effort – the "vast" number of people who came to help – was "astonishing" to Levy, who was touched by the sincere outpouring of desire to be of assistance, to give back to less fortunate others in the community. He noted that the helpers reported how satisfying it was to reach out, a sentiment which resonated with him:

"Being a part of this mass effort added to my own life more than I ever imagined, and the camaraderie that developed among volunteers was remarkable. Without this mass effort of volunteerism, the community could never have been rebuilt, which highlights how important people are to their communities." (Levy, 2008, p 34)

Support is the name of the game Finally, few volunteers – whether reporting on Katrina or on other disasters – would deny the ultra-importance of support. Whether they were advocating for support for the original client group that they had come to serve – the survivors and disaster-affected – or they were talking about support for their team members and other relief workers, or simply noting that they needed it for themselves, the psychologists of Hurricane Katrina extolled the merits of offering support. Rosser advised supporting the caregivers, remarking that it is just as necessary in the aftermath of a disaster to support the ones supporting the survivors as it is to support the survivors themselves. He gave the example of one household who had invited 19 evacuees in to stay, not knowing when they would be able to move out. They needed both emotional and practical support (the latter being such as finding personal time for the owner of the home) (Rosser, 2008).

Osofsky detailed many vignettes of support offered, and finished her report noting that one of the big lessons she had learned from her Katrina experience was that she needed time-outs to support herself (Osofsky, 2008). Rosser concurred, stating that he had never even owned a mobile phone prior to his deployment (by choice), but that it had proved to be a critical connection to his family and colleagues back in "normal" life, and an essential tool for activating his own support system. In addition to finding time to meditate, connect, retreat, hug, hydrate, eat, and tell their stories to one another, developing personal support systems – and defusing frustration - for Rosser's team meant developing humour (a point noted by the North Carolina team as well). They offered examples:

"We have found the disaster, and it is us!" (Haskett et al, 2008, p 98) "Avoid blaming until later; it ruins a perfectly good disaster" (Rosser, 2008, p 42)

The North Carolina psychologists voiced well what nearly all said in one way or another about their experience of serving:

"New alliances were established between diverse professionals (i.e., age, geographic origin, occupation, gender, race, and ethnicity) who had common values and professional goals. It was these relationships, developed among supportive peers, that affirmed and sustained the efforts and energy necessary to provide mental health services for clients as well as staff. We remain in contact with members of our volunteer groups, who continue to be a source of personal and professional support because of the meaningful connections formed through working together." (Haskett et al, 2008, p 97)

What is your reaction?

You've now read many pages about the experience of people deploying to a real disaster zone. If you had to name one word or phrase to express how you are feeling about the possibility of serving in this same way, what would it be? Has reading this increased, decreased, or not changed at all your feelings and expectations about doing Psychological First Aid?.

Self-care and stress management

Rare would be the text or field operations guide for disaster mental health responders – or any disaster relief personnel - which did not expressly mention the supreme importance of self-care and stress management when volunteering at a disaster scene. Mental health professionals, such as the psychologists we reported on above, have noted without exception that they would not be able to psychologically survive the gruelling and emotionally demanding nature of the work if they did not tend seriously on their off-hours (few though they may be) to de-stressing and self-care tasks. Beyond being a necessary endeavour for oneself, managing one's stress is another way of supporting people affected by a disaster, in that when we are relatively less stressed we are more fully able to be an empathetic, actively attending presence for a traumatised person.

Effective Stress Management

We can define stress as any pressure, demand, or threat placed on a person that causes a need to re-establish balance or "equilibrium". The Oxford Dictionary (online) notes that stress is: "a state of mental or emotional strain or tension resulting from adverse or demanding circumstances". There are three main components of a stress management program which must be factored into any regaining of equilibrium in a disaster setting: self-awareness, self-regulation, and balance. We identify sources and signs of stress that, as a psychological first aider, you must be on the lookout for, and we offer strategies noted by other disaster mental health volunteers for dealing with common stressors.

Self-awareness For mental health professionals, being self-aware is significantly associated with effectiveness of the helping (Strupp, 1996). Without awareness, we cannot regulate ourselves, and without self-regulation, we cannot achieve balance. When we act with self-awareness, we allow into consciousness our full physical and psychological experience – without distortion or denial. Understandably, the intense, life-and-death nature of disaster aftermaths brings to the fore any unhealed wounds, unmet needs, or deep concerns normally residing just out of awareness in our psyches. In some ways, the experiences of the people we are trying to assist may resonate with us, causing hidden material to surface and demand attention. As an example, a psychological first aider trying to comfort a young person who just lost her parents in the floods may find themselves easily triggered into tears, and realise that they never grieved properly for their own parents' deaths. Material that has not been worked through is sometimes raw, and it threatens our sense of self. But without awareness of it, we run a serious risk of harming the survivor-clients we are trying to assist. It can happen through either neglect or exploitation of them as we attempt to meet our own needs (say, for belonging, esteem, or status) through our interactions with them. We will identify a number of stress management strategies that have enhanced self-awareness as their goal.

Self-regulation More than in any other setting, disaster fieldwork requires helpers to be able to self-regulate. This is logical, because the situation itself feels completely unregulated and out of control. Endemic to a mass incident is a heightening of fear, dread, emotion, energy, and loss. Yet it is those very factors which make it more difficult for disaster responder to regulate their own bodily and emotional drives, impulses, and emotions. While normal stress management can see people occasionally having too little stimulation, this is almost never the case after disruptive events, where everyone at the scene is highly overstimulated. Thus self-regulation here calls for the ability to defuse emotionally charged experiences and thus regulate mood and emotion. How we relate to food and drink also figures into good self-regulation, as many disaster volunteers have talked about having to manage taking time out to eat and hydrate enough to continue being effective. The goal is to learn what we need to do to bring ourselves into equilibrium: a balance achieved by self-regulation, which was made possible by self-awareness. We will list some stress management strategies that psychological first aiders have used to help regulate themselves.

Balance Think about it: as a psychological first aider, you might be on a two-week deployment, working 10 – 12 hours shifts with few breaks. You may have as little as one day off during that time. There are loss, destruction, and traumatised people all around you, and – unlike in your days at the office seeing clients, where six clients might be a full day – you may have 50 – 75 "client" contacts during the shift. And you are supposed to attain "balance"? Yeah, right. The situation simply does not lend itself to that.

Walking a tightrope between caring for others and tending to your own needs of body, mind, and spirit may seem impossible in a disaster field setting, and no one pretends that it is easy. But it is no less important for that. Nurturing connections with ourselves, between ourselves and others in the environment, and between ourselves and "the transcendent" ("God", "the universe", or even just the "something more than": however you name it) lead to balance and are essential for stress management. We are told this by most of the world's religions, and now many scientific studies are backing it up (Treadway, 1998). Gaining a measure of balance (not a static thing, but always moving and dynamic), we achieve a sense of mastery and esteem. On the frontline of a disaster, a sense of balance translates to a critical sense of control in an out-of-control environment. All of that is not controversial. The question is: how does one do it, especially in the middle of a disaster aftermath?

What follows are sources and symptoms of stress and techniques for managing it.

Sources and symptoms of stress

In "regular life" sources of stress abound, generating symptoms of stress. This is even truer of disaster scenes.

Sources of stress can be divided into three categories:

1. Personal stressors, such as events that happen to us and our perceptions of those events, fears, self-doubts, questions about our own usefulness, and any problems in relationships. Unrealistic, limiting attitudes, such as perfectionism or being demanding, are also part of this category;
2. General environmental stressors, referring to external factors such as not having enough money, poor quality housing, or a poor physical environment – all of which define "normal" in disasters;
3. Special environment stressors, which could include something as ordinary as a work or family event, but in the aftermath of a disruptive incident means the now destroyed environment as well.

Interestingly for stress management, stress is at least partly a function of our reaction to perceived threat, pressure, or demand. Thus, two volunteers in a cyclone aftermath may have reactions to a given aspect of the cyclone which are very different from one another. But even reactions within our own selves may vary widely. On one day we may cope quite well with, say, dealing with others' losses; the next day we may find it overwhelming.

Beyond that, in a setting where we are trying to assist people who have lost just about everything, including family members or friends, there are additional sources of stress. Many of the psychologists reported on earlier expressed concern that they could not do more to help. They had doubts about the value of their helping, could not sleep for worrying about the survivors they had just worked with, and

of course saw many times the typical number of "clients" that they would have seen in their offices back home (Rosser; 2008; Levy, 2008; Haskett et al, 2008). Studies showed that these are among the more common concerns for mental health helpers even in non-crisis settings (Deutsch, 1984).

Common symptoms of stress Both disaster survivors and the disaster relief teams assisting them may be vulnerable to stress. The following list shows some common symptoms that psychological first aiders may experience when working with survivors:

Physical	Mental/Emotional	Behavioural
Poor eating	Depressive symptoms	Substance use
Poor digestion	Fear or anxiety	Increase or decrease in activity level
Stomach ache	Numbing	Poor attention
Nausea	Undue concerns	Disorientation
Dizziness	Low self-esteem	Difficulty making decisions
Headache	Irritability	Reduced scrutiny
Broken sleep	Anger and frustration	Wanting to hide
Excessive dreams	Feeling alone	Decreased scoial activities
Rapid breathing	Feeling lost	Abnormal 'after the event' thoughts
Racing heart	Feeling guilty	
Aching muscles	Memory lapses; forgetfulness	
Easily startled	Becoming easily upset	
	Slowed or confused thinking	
	Vicarious traumatisation, such as shock, fearfulness, horror, helplessness	

(Clarke, 1998; Brymer et al, 2006)

Extreme Stress Reactions Psychological first aiders may occasionally experience such horrific scenes in the disaster setting that they experience more serious stress responses, ones that warrant support from a professional or monitoring by a supervisor. Some of these are:

- Compassion stress and/or compassion fatigue
- Feeling depressed accompanied by hopelessness (placing helpers at higher risk for suicide)
- A sense of demoralisation, resignation, or feeling alienated,
- Compulsively re-experiencing trauma that either they or survivors they were helping experienced
- Attempts to over-control in professional or personal situations
- Withdrawing and isolating
- Having serious difficulties in interpersonal relationships, including domestic violence
- Becoming suddenly "workaholic" or extremely preoccupied by work
- Preventing feelings by relying on substances
- Avoiding sleep or feeling a need to sleep all day
- Engaging in elevated and unnecessary risk-taking

(Brymer et al, 2006)

If you notice any of the above behaviours in either yourself or a fellow responder, it is essential to bring it to the attention of senior mental health helpers present at the disaster site.

Strategies for managing stress Disaster experts warn that post-trauma stress symptoms still hanging around after a month become part of PTSD: Post-Traumatic Stress Disorder. The more stress management strategies a person has, the more chances he or she has to change the conditions (if possible), or change the reaction to the stressor (if it cannot be removed), in order to avoid being incapacitated by PTSD. How many of the following might you already employ? How many might you be likely to utilise in a disaster-zone deployment?

Strategies to tend to body:

- Exercise. It's true: experts recommend 30 minutes a day, minimum, of varied types of exercise, including strength training, cardio-development (such as jogging), and stretching exercises (e.g., yoga, Pilates, tai chi). Given that there may not be a gym at the disaster command centre from which you are working (!) and that your workdays may be very long, which types of exercise might you reasonably have a chance of doing?
- Food: We can't cut this one out completely if we find that we are stressing ourselves through "addictions" to it, but if you are planning to go serve somewhere in the aftermath of a disaster, it is worth noting how you would cope without some of your favourite comfort foods, if they were not on the scene, or with the possibly less attractive choices available at your deployment location. Here balance becomes an important watch word, as too little food (through not taking time out to eat it), or too much food (through comfort over-eating) may end up as either stressors or poor stress management strategies. Your at-the-disaster eating plan may look different from your way of doing food in "regular life", but you can still practice the three pillars of stress management through your food intake: that is, awareness, self-regulation, and balance.
- Substances: How well are you able to control the use of substances such as nicotine, caffeine, and alcohol? Described sometimes as "false friends" because they are attractive, but then let us down, these substances can hamper effectiveness during emergency fieldwork, where the best strategy seems to be to limit their use (Brymer et al, 2006). If you "must" have something, you are attending to your needs, not those of the person that you purport to be serving.
- Rest: There is no disagreement on this point: managing to get sufficient sleep while you are doing disaster mental health volunteering is IMPERATIVE! There is little disagreement on this point as well: managing to get sufficient (quality) sleep while you are doing disaster mental health volunteering is EXCEEDINGLY DIFFICULT! The horrible scenes witnessed by many survivors will return unbidden to them, especially in the quiet hours when they are otherwise unoccupied. Unfortunately, psychological first aiders are likely to experience secondary or vicarious trauma through what they see and hear, and this may happen to you, too. Deep sleep is highly restorative; poor sleep is just another stressor. Strategies for getting a good night's sleep in normal circumstances still prevail: that is, getting exercise, limiting caffeine intake in the evenings, not exposing oneself (if possible) to disturbing images close to bedtime, and a calming bath (or if that's not possible), shower.
- Medical care. Proper medical and dental care is a good stress management tool anytime, but for the psychological first aider, it is best before turning up for the disaster. Earlier, we encouraged you to assess before putting your hand up whether your health would permit long hours of activity with little rest, and coping with the conditions of many deployment locations. If you have a "yes" for that, you still need to bring your medical care up to date before entering the disaster setting, because the resources there for attending to helpers, especially, may be quite thin on the ground.

Strategies to tend to mind/emotions:

- Identifying and replacing stress-inducing attitudes. How many life-restricting attitudes can you identify within yourself? Many of these may have been with you from such an early age ("planted" or "introjected" by early caregivers) that they do not feel foreign, and may not be that bothersome in "regular life". In the intensity of a disaster aftermath, however, you may find that these unrealistic, limiting, distorted attitudes make your service unnecessarily stressful, causing anxiety, self-doubt, and discouragement. Here we are talking about such as:

- Rigidity
- Perfectionism
- Intolerance for self and others
- Compulsion to overwork
- Messages of unworthiness
- Obsession with envy
- Feelings of incompetence
- Phobias
- Fear of committing
- Non-acceptance of self
- Non-acceptance of others
- Bitterness
- Unprocessed regret
- Sense that the world "should" be a certain way
- Distorted sense of control
- Lack of perspective
- Placing conditions on happiness
- Lack of gratitude

If you are already a trained mental health helper such as counsellor, psychologist, or psychotherapist, you will know techniques for stopping such thoughts and replacing them with kinder, more realistic, statements about yourself, sometimes called "disputations". The disputation helps us to solve problems where the original statement, a "cognitive distortion", would tend to keep us stuck. Which attitudes or beliefs do you identify for yourself as issues? How do you currently deal with these? How else might you handle them? The practice of unconditional self-acceptance and compassion – especially working in a disaster zone, where you may not know what to do or how to engage it – is a good place to start. The more we can be in right relationship with ourselves – meaning that we are living from a genuine place of feeling ok about ourselves – the more resources are freed up for empathetic, compassionate relating to others, especially traumatised others.

- Developing and maintaining meaningful human connections. Not much more needs to be said on this point, except to reiterate that it is through genuine human connecting that we both gather and give that all-important social support, a primary stress-buster and resilience tool in both disaster relief and regular life (Bokhorst, Sumter and Westenberg, 2010; Carbonatto, 2009). We've noted how the recipients of Psychological First Aid have been immensely grateful for it, and the psychological first aiders have come away after serving with the sense that, because of whom they were able to connect with, the experience of serving in a crisis was deeply rewarding (Osofsky, 2008; Levy, 2008). All of the psychologists whose reports we included spoke of the primary importance of supporting one another through mutual processing of disaster service experience (Levy, 2008; Rosser, 2008; Haskett et al, 2008; Osofsky, 2008).
- Taking "down time" and time to replenish. It seems like a contradiction in terms: you volunteer to go to a crisis or disaster scene to help out where chaos seems to reign, and there are thousands of people with gaping unmet needs for basic as well as emotional support. Even if the volunteers work long hours for many days, the available pool of disaster relief workers cannot hope to meet all the needs, less so the much smaller cadre of disaster mental health personnel (of which you are one) assigned to the particular location. How on earth in these circumstances can you take "down time" to replenish yourself, even if you agree that doing so is a worthy goal? The short answer is that, even if you cannot, you MUST. From the Psychological First Aid Field Operations Guide to the WHO Field Guide to the individual psychologists, we have the crucial advice to:
    1. Take short periods during the day to eat, take care of your body, rest, relax, or do other stress management techniques
    2. Notice when you are Hungry, Angry, Lonely, or Tired (HALT), and stop to do some self-care

3. Increase time for positive activities
4. Take time to draw, paint, or write (many have commented how important keeping a diary or journal is)
5. Practice brief relaxation techniques during the workday
6. Self-monitor and pace your efforts (Brymer et al, 2006; World Health Organization, War Trauma Foundation and World Vision International (2011); Rosser, 2008).

- *Self-care rituals.* Self-care rituals span the spectrum of body-mind-spirit strategies for managing stress. The iconic "warm, relaxing bath with lavender" may be unachievable if one is sleeping in an army cot with communal showers in another building. Perhaps the rituals which are effective while doing disaster mental health fieldwork revolve around seeking needed support from family, friends, and colleagues: e.g., Rosser's (2008) comment that he had never chosen to own a mobile phone until his deployment in New Orleans after Hurricane Katrina, but then it was essential for staying in touch with family back home and colleagues at other disaster locations. Or perhaps the ritual is a simple but lovingly carried out act of grooming, or a daily visualisation program. Whatever we do, it is performed with the idea of calming and centring ourselves, and gently bringing ourselves to another perspective.
- *Strategies to tend to spirit.* The guidebooks and mental health experts are clear: practicing religious faith, philosophy, and spirituality is essential for optimal stress management in disaster mental health volunteering. When we connect with spirit or spiritual experiences (however we conceive those), we counter the mental and physical symptoms of the stress response (Benson, 1996). Moreover, when we engage stillness activities such as prayer, meditation, and contemplation, we not only engender a sense of wellbeing, hopefulness, and optimism, but we also generate higher levels of functioning and accelerate our own healing (Miller, 1999).

Stress management techniques, strategies, and approaches are myriad, and given how highly stressful disaster mental health responding inherently is, wise volunteers stuff their psychological tool kits with as many options as possible for keeping on an even keel during a deployment, with the ultimate aim of offering the highest quality presence, or "beingness" to those being served.

Linking in with your stress management regime

How would you describe your stress management and self-care regimes for "normal" (i.e., non-disaster) life?

- How attuned are you to the issues of maintaining self-awareness, self-regulation, and balance?
- Which of the listed stress management strategies do you do regularly (be honest!)?
- Which category of stress management strategy (meaning, strategies for body, mind, or spirit) do you find the most challenging to maintain on an ongoing basis? For example, you might be very regular in your chosen exercise program, but find you occasionally slip into stress-inducing thoughts, such as perfectionism or rigidity.
- What one strategy or technique might you be able to adopt today? Even a very small change, practiced with consistency, can yield big results.

Working through personal issues

Self-exploration: why bother?

We've alluded to the issue of disaster responders' psychological material, often just out of awareness, which gets triggered into conscious awareness in moments of trauma, especially, trauma which in

some way resonates with the helper's experience. Obviously, the more unworked-through material we are holding, the more potential there is for us to get triggered (read: traumatised) when working with similar pain in disaster – affected people. So, what can we do about this if we would be optimally resilient offering Psychological First Aid on the frontlines of disaster aftermaths?

The answers are not easy or quick, and - if someone is merely looking for an opportunity to do a quick two-week deployment and then go home, never again to do disaster mental health response – the answers are also not convenient. This is because working through personal issues is not a quick-fix solution. It is about the long-haul personal transformation that, over time, enables us to serve, even in highly-charged, high-stress situations, with a modicum of empathic presence and abiding calmness. The good news is that one's personal program of self-actualisation does not need to be completed before entering the field (impossible, anyway, as there is always more growth and development we can experience); it only needs to have been started, so that as a disaster mental health responder you are aware of your issues, and capable of dealing with them, even in intense situations.

Mental health experts suggest several ways in which you can identify and resolve such unfinished business, often related to your family of origin. There is little disagreement that you must do this if you would avoid repeating negative patterns of interaction. A thorough examination of your family structure and history can help you to understand which beliefs, attitudes, and values you may have "adopted" (or had foisted onto you) from your family. Going into a period of therapy or other self-exploration can give you the necessary insights to see how past conflicts and hurts are still affecting you. We discuss the options of individual therapy, group counselling, "self-therapy", and adventure and escape as means of working through your personal issues.

Options for self-exploration

Individual therapy The debate rages in counselling institutions as to whether people working as mental health helpers should be required to get their own personal therapy, or only recommended to do so. Individual counselling offers you the opportunity to explore your problems in some depth, and seems to be a necessary component for the growth of helpers. Consider these potential benefits that you may derive from a period of it: alleviating personal distress; gaining insight into being an effective helper; and developing enduring and healthy self-care habits (all of which are critical when working in disaster settings). Additionally, you may be drawn to working through your personal issues through individual therapy because of tendencies in yourself that you have discovered in starting to do Psychological First Aid, or possibly other helping work. Common challenges to overcome are:

- A tendency to tell survivors and supported people what to do
- A desire to alleviate survivors' pain
- A need for quick solutions
- A fear of making mistakes
- A desire to be recognised and appreciated
- A tendency to assume too much responsibility for the supported person to change
- A fear of doing harm, however inadvertently
- A tendency to deny or not recognise issues in the supported person that may relate to the helper's own issues

(Corey et al, 2007)

Group therapy Best viewed as complementary to individual therapy rather than a substitute for it, group counselling has many advantages for the helper growing in self-awareness. As a member of a group, you are able to receive feedback from others. The experience of participating in a group can help you to be more aware of your interpersonal style – hugely invaluable information for you as a helper – and give you the chance to experiment with new behaviours in a "safe" setting. Reactions you get from others can help you to understand how your personal traits can both serve and limit those you are helping. And unresolved family-of-origin issues can often be worked on, so that you begin to let go of attitudes, beliefs, and values (seen as family "rules") which might have served you when you were young, but which may be causing you to feel stuck now.

Whether we are considering individual, group, or "self-therapy", we do not have to regard it as something that we do only when we are deeply disordered. It can help us gain deeper understandings of our personal strengths and growing edges, our deeply-rooted tendencies, and our most strongly-held motivations. It can serve different purposes at different stages of our work and life.

Self-therapy If you have been helping people for some time, even as a lay person, you undoubtedly have a growing repertory of "tricks of the trade" – types of responses, interventions, strategies - that you use to uplift, inspire, or sometimes challenge your clients. If your helping methods work for clients, then they will work on you, too. Pep-talks to helpees can motivate you. Challenges to those you are supporting to release things that are keeping them stuck can be messages of release for you. If you have been assisting others to counsel themselves, you can internalise the same helpful messages. In short, if you are a helper, you are probably good at convincing people to do what is best for them. When you are working through personal issues, you can use that same authoritative helper voice on yourself.

One way in which you can "hear" that voice is through keeping a journal. Not only does the act of writing something out serve us as catharsis, but it also tends to help us clarify what is really going on for us with an issue. Systematic journal writing, strongly advocated for psychological first aiders, has been noted to serve in four ways:

1. *It is a way to supervise oneself and one's work through difficulties with particular cases.* If a survivor or disaster-affected person presents with a similar situation to what we have helped someone with before, we can review the journal to find what interventions and strategies we successfully – or not – used before in order to avoid repeating mistakes.
2. *It is a method of self-analysis.* Especially during periods of intense work and correspondingly intense introspection, a journal can become a repository for the stuff of which analyses are made.
3. *It is a vehicle for developing and recording ideas.* Plans, dreams, and theories can all be articulated in a journal, for later retrieval and analysis, or even just to mark our progress generally as growing beings, and particularly as responders in disaster relief work.
4. *It is a record of significant events.* As helpers, we are often aware of how the past creates the present and future. We may be involved in hearing the story of someone where, by listening to them disclose other critical incidents in their life (say, before the current disaster), we see how the present situation came to be as distressing as it is for them. We can do the same study for ourselves if we have recorded the data of our experiences. And a journal can become a structure for committing ourselves to future goals so that we can continue to grow in work and personal effectiveness (adapted from Kottler, 2003).

Adventure and escape If we need to regain a sense of perspective, getting away from our homes and our regular lives for a bit of adventure or travel can do just that. Kottler (2003) makes the point that what he calls "transformative travel" (p236) has many of the same elements of good counselling. Insulated from our usual experiences, we can more easily take on a mind-set that is ripe for change. Moving through time in an unfamiliar place can heighten our senses and usher in an altered state of consciousness. Facing our fears and possibly getting lost, we experience emotional arousal. If we then reflect on what happened on the trip and make sense of our experiences, we can transfer that learning back to other aspects of our lives. Some would argue that merely serving on a "frontline" experience in the aftermath of a disaster can bring about some of these changes, thus ensuring that self-exploration has occurred in time for future deployments.

Defence mechanisms: red alert

All of the above means of self-discovery can be useful and appropriate in some circumstances. The point of them is that, as mental health helpers, we aim to be open and undefended in our approach to life and relationships. We set up elaborate plans for how to scrutinise our psyches in the interest of attaining a high ethical standard. That examination of our own unprocessed psychological material is grist for the mill of both our professional and personal development. At the heart of what we are trying to transform with all the personal work is what are sometimes called defence mechanisms. They develop out of our awareness to protect us against psychic pain, and they hang around our personalities so persistently because, at one time, they served a useful function.

Here is an example of how one could form. Let's say a child was exposed to a lot of violence and unregulated emotion as a child; perhaps her father regularly beat her mother. She might come to believe that all emotion is bad, because from her experience, all observed displays of emotion led to a dangerous situation. Thus, she might make very sure that, if any of her emotions came bubbling to the surface, she quickly squashed them down. She might, through the years, have gotten so good at doing that, that emotions no longer come to her consciously. In fact, over time, she might come to "forget" all of the violence as well. When she not only cuts off her feelings and forgets that she has had them, but forgets what the forgetting was about as well, she has created a defence mechanism of repression. When we forget, and then forget that we forgot, there is little easy access to what has been repressed.

Let's say that now the girl, as an adult, wishes to become a psychological first aider. She signs up for a role at a refugee camp in a war-torn African nation, and begins to hear stories of brutality perpetrated on women as they flee to the camp. She may be able to function in such a helping role at the beginning, but is likely to become increasingly heavy-hearted and numb to the women and their plight. Or at some stage, things may go the opposite way, and she finds that she becomes unreasonably agitated, or even begins to sob uncontrollably in front of women whom she is helping. Now her defence mechanism of repression is limiting her work more than it is helping her to "hold it together" as it did when she was a child. The defence served its purpose many years ago, but the "limit" side is dominating now, and it is time to begin healing it: that, or she will not be able to work effectively with the women.

Why working through issues may even be harder for mental health helpers than lay people

It is neither easy nor painless to look at the ways in which we emotionally protect ourselves. Mental health helpers, especially, are vulnerable to thinking that they of all people should have worked through their personal issues, and shutting down the whole "excavation" process with denial is highly tempting. As a group, helpers are said to tend toward "shame and silence about true self needs" (Saakvitne & Pearlman, 1996, p 41).

Some helpers feel huge anxiety, and others are in the throes of toxic shame at the thought of acknowledging such raw, primitive material. The Rx for action on defences, though, is as we said at the beginning of this chapter on stress management. We must first allow in the light of awareness of ourselves. Then, insight in hand, we are able to choose to self-regulate. In this case, that would mean doing the work of delving into the defended material and acting from awareness rather than denial. When we can know that we have had a defence operating and yet be able to spot its effect in our lives or work, then and only then can we come into a place of balance, where we hold the "both and". That is, we can say "It is both that I have a defence, and that I have processed it enough that I can work with people whose pain is similar." Reaching that stage of development, we can see how self-care and care for those we are supporting is a single intertwined thread.

Self-exploration: Pros and cons of your top choices

Review the list of possible means of self-exploration above, and decide which two ways of gaining more self-awareness and working through your personal issues seem most workable for you at the present time in your life.

1. What are the advantages and disadvantages of each one? For example, adventure travel might sound like the most fun, but it can also be expensive, and is not generally accessible on a regular basis.
2. Which one are you more drawn to now? Why?
3. What one step are you willing to take today to learn more about yourself and your issues?

Whether you engage periods of individual therapy, embark on a series of group therapy sessions, provide self-therapy in some way, or engage in some other means of self-exploration, such as adventure travel, the rewards for working through personal issues are numerous. Not only do you access a more expansive self-understanding, but also you carry the quiet confidence when you are serving as a mental health helper – especially in a crisis – that you have begun the process of doing everything in your power to be fully present with all whom you assist.

Some concluding thoughts on getting into the field

Perhaps this chapter should be called, "What I need to know and be able to do in order to psychologically survive as a psychological first aider in a disaster". That's a mouthful! But particularly when we are talking about crisis settings, "forewarned is forearmed." That is, your deployment has a far greater chance of success if you know what competencies you will need to exhibit, and work steadily beforehand to attain those. You are at a higher level of preparation psychologically if you have heard or read about the experiences of others doing what you are planning to do; you thus know part of what you can expect. And you are likely to be most grateful to yourself (and maybe to this course as well) if you go into a disaster setting with some seriously unshakeable self-care and stress management routines: ones that you know are highly effective at calming and centring you, helping you to shift perspective, and come back to your preferred state of being a deeply compassionate, supportive listener.

Much is asked of the psychological first aider who would be of genuine assistance to those suddenly in dire straits. Yet if the experiences of those who have served as disaster mental health volunteers are anything to go by, the profound gratitude of the survivors you help will make you count as weightless the lengthy preparation for your deployment and the discomfort of its environment. Rather, you will bathe in the torrential blessings that descend on you when you realise how – even if only in small ways – you have truly made a difference.

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Chapter 7

Practical Preparation

The aim of this course has been to equip you to do Psychological First Aid in the aftermath of a disaster or mass disruptive event. To that end, we have brought you through a process of exploring what Psychological First Aid is, and also the "who, what, when, where, how, and why" of its delivery. We have extensively reviewed the core principles and actions that comprise it. And we have included a chapter on what competencies, skills, and personal circumstances you will ideally have upon deployment to a disaster, so that you can assess for yourself how ready you are. We have offered you the experiences of veteran mental health disaster responders, so that you can know what to expect upon entering a disaster scene. We have even detailed a recommended pre-deployment program of self-care and self-exploration to ensure your maximal comfort and effectiveness in any field setting. Our mission is nearly complete.

We would like to add just one more piece to the jigsaw puzzle of your understanding: a practical piece. This chapter helps you to avoid re-inventing the wheel by offering you some handouts which may be useful in a deployment, and by listing some organisations which may be relevant in order to find out more about Psychological First Aid, and about how it happens through organisations. Finally, we send you on your way with some concluding thoughts.

Objectives

Thus, our objective in this last chapter is simple. Upon successful completion of Chapter 7 you will have access to:

1. Useful handout templates, both for yourself and also to give to client-survivors
2. Names of provider and other relevant organisations, to enhance your knowledge about Psychological First Aid and to help you connect with those involved in it.

Worksheets for you as psychological first aider

One of the realities of the disaster aftermath scene is that you may be involved in the referral of "clients" to other services: especially if you are a lay person (not trained in mental health), but even if you are a professional. In this case, the receiving service or professional will be very keen to know about two aspects:

1. What your (hopefully thorough) interview turned up in the way of the survivor-client's needs;
2 What aspects of Psychological First Aid you have already provided.

Even if the person does not get referred on, it is useful for you (and conforms to the highest standards of ethical behaviour) to make notes on what you observed and found out when you spoke with them. When you may have many survivor contacts in a short period, it also helps you to keep from confusing

the various "clients" in your mind. You will be especially grateful to your own diligence in recording these basics if at any stage you are discussing the cases with a field supervisor. The following two documents are suggested templates that you may wish to photocopy (over and over again) for use with each "client" with whom you engage.

Download Survivor/client needs (PDF)

Download Components of PFA provided (PDF)

Handouts for your clients (survivors and other disaster-affected persons)

Unless there are language or literacy barriers, giving the people with whom you engage handouts summarising aspects of how they can cope better post-disaster serves numerous functions:

1. The handouts jog their memories about additional information and coping strategies that will be useful as they go through the process of disaster recovery. These will often be items that you mentioned – possibly multiple times - in talking with them, but in their dazed, "shell shocked" state, they may not have been able to take on board.
2. Like giving a worried child his favourite toy to sleep with, the handouts can have the effect of calming them and providing a sort of continuity of care: that is, the handouts remind them of you and the compassionate attention that you directed their way while they were at their most vulnerable. In that way, merely reviewing the sheets can serve a healing purpose.
3. Because the information on the handouts is practical and relevant to what the survivors and many in the community will be dealing with, the handouts may potentially be shared with others, thus extending the reach of the Psychological First Aid, and enlarging the community's capacity for coping to a much wider circle. (We did promise to show you how to become the rock of helping dropped into the pond of vulnerability).

The handout documents we have included are:

- Tips on how to seek social support
- Tips on how to offer social support
- Dealing with terrible things that happen
- Tips for relaxation
- Alcohol and drug alert

Tips on seeking social support

The research on social support is overwhelming, and it confirms what we know instinctively: connecting with others when we are distressed helps us to reduce feelings of overwhelm, distress, and sadness, and accelerates our recovery.

With whom can you connect for support?

Spouse/Partner	Parents	Trusted family members
Close friends	Co-workers	Teachers and coaches
Members of the clergy	Church members	Support groups
Counsellors	School counsellors	Crisis counsellors
Doctors, nurses	Even your pets!	

How can you link up with these support options?

- Call friends and family members whose numbers you have, and request time
- Renew (or begin) involvement with a religious or spiritual group
- Join a support group
- Increase contact (say, by phone or email) with friends and acquaintances
- Get involved in community or school events or recovery activities

Your support is enhanced when:

- You ask others if it's an ok time for them to talk/meet with you
- You carefully select your listeners/helpers: not all people are equally skilled or willing to lend social support, even if they care a lot about you
- You show gratitude for their listening time
- You decide before the meeting what you want to discuss, and don't feel pressured in the meeting to talk about painful things if you are not ready
- You choose a time and venue that suits both of you
- You let your supporter know if you want to talk, or prefer to just have them there with you
- You start with practical matters (not always the best way, but often helpful)
- You focus on just one thing that the supporter could do to help you right now

Your support may be diminished (or not come to you at all) when:

- You assume that others don't want to listen
- You worry about being a burden and say nothing
- You decide that you must not say anything because someone else may get upset
- You wait until you are really in a bad way (highly stressed, exhausted, or unwell) to ask for help (by this stage you may need professional help instead)

Tips on offering social support

Probably the single most helpful thing that you can do to assist family members and friends in getting over the disaster is to spend time with them and listen deeply to them. This means that you may not talk very much, and for that matter, they might not either. Sometimes people can feel so overwhelmed by a catastrophic event that they are not ready to talk about it for some time. Just spending time with them and showing your care and acceptance is healing. They will talk about things when they are ready if they sense that you are genuinely there to listen. Here are some tips on offering social support.

Give support by:

- Finding a quiet, private place where you can be together without interruptions (turn your phone off!)
- Showing respect for whatever reaction the supported person is having, and for how they are coping (even poor ways of coping, such as with excessive alcohol, can change more easily if people feel accepted)
- Showing interest and care through your listening and attending behaviours
- Maintaining a non-judgmental attitude
- Letting them know that this sort of stress can take time to resolve, and that intense emotional and other reactions are expectable after a disaster
- Affirming your belief that they can recover
- Brainstorming additional coping strategies with them
- Offering to meet with them again, as much as needed, until they feel better

Don't try to "support" by:

- Insisting that they "just get over it", or treating them like they are weak or cowardly
- Telling them things such as that they were "lucky" – it could have been worse – or that what doesn't kill them will make them stronger
- Stopping them from speaking about what is worrying them (you may be doing this more to meet your needs)
- Telling your own stories of recovery or other experiences instead of listening to them
- Spouting advice, especially without asking them what they need

Know that – whatever you do or don't do – some will feel uncomfortable to ask for support, and sometimes your best support will not be enough:

- People are afraid to burden others, or doubt that support will be helpful.
- Survivors sometimes want to avoid thinking about the event, or fear they will lose control.
- Some have had poor "support" in the past, and/or assume that they will be judged negatively.
- You can let them know that receiving social support aids recovery.
- You can encourage them to talk with a counsellor, clergy member, or other professional, and even go with them to the appointment.
- You can encourage them to join a support group of others with similar experiences.
- You can recruit others from your social network to join in supporting the person.

Dealing with terrible things that happen

Survivors can have a wide range of reactions to disaster. Some reactions will occur immediately, and others will be continuing for some time afterward. Many of the responses will be judged as "negative", or limiting to the person, but there can also be "positive" reactions, which serve the development of the person and the whole community.

Immediate reactions:

- ***Limiting cognitive/mental responses*** can include: confusion, self-blame, worry, intrusive thoughts and images, and disorientation.
- ***Cognitive/mental responses which serve*** include: a renewed sense of optimism and faith, deepening courage, greater courage and resolve, increased clarity of perception and insight, determination.
- ***Limiting social/emotional responses*** may be: shock, fear, anger, sadness, grief, numbness, guilt and shame, irritability, interpersonal conflict, and withdrawal.
- ***Social/emotional responses*** which serve the person include: feeling mobilised, challenged, and involved, strong helping behaviours (altruism and philanthropy), and social connectedness.
- ***Limiting physiological responses*** may be: fatigue or difficulties sleeping, headache, stomach ache, increased heart rate, muscle tension, and hypervigilance (e.g., easily startled).
- ***Physiological responses which serve*** include: an increased sense of energy and readiness to respond, high alertness, a sense of feeling very alive.

Reactions which continue over time are mostly unwelcome and include:

- ***Avoidance and withdrawal reactions***, such as not wanting to talk, think about, or have feelings about the traumatic event; avoiding reminders of the event (places, people, and things connected to the event); feeling detached and estranged from others (withdrawing); feeling numb (feelings become restricted); and losing interest in formerly pleasurable activities.
- ***Intrusive reactions***, such as: having "flashbacks" where it is as if the event is happening again; experiencing distressing thoughts or images of the event while awake or dreaming; having upsetting emotional or physical reactions to reminders of the experience.
- ***Physical arousal reactions:*** difficulty falling or staying asleep, problems concentrating, being constantly "jumpy" or on edge and looking out for danger (hypervigilance), and irritability or outbursts of anger.

- ***Reactions to trauma and loss reminders*** include reactions to places, people, sights, sounds, smells, and feelings that are reminders of the disaster, and these can bring on upsetting thoughts, physical or emotional reactions, or mental images. Triggers can be things such as sirens, loud noises, television/radio news broadcasts about the disaster, funerals, anniversaries of the disaster, seeing people with disabilities, and being at locations where the disaster occurred.

Positive, serving responses that come with the fullness of time include:

A shifting of priorities and world view towards greater appreciation of and time spent with family and friends; increased commitment to self, family, friends, and spirituality or religious group; shifting expectations about what can be accomplished, or what constitutes a "good" day; and a sense of renewed capacity for meeting the challenges (often including an increased sense of humour and acceptance). People may experience a deeper sense of the meaning and purpose of their lives.

Reactions specific to a loved one's death include:

- Nausea, fatigue, muscle weakness, and trembling or shakiness
- Feeling bewildered, lost, confused, or just numb
- Intense emotions such as extreme fear, sadness, or anger
- Feeling anger at either the deceased or those who are held to have caused the death
- Difficulty making decisions or being productive
- Missing and longing for the person who died
- Being at higher risk for physical injury and illness
- (For children) becoming anxious that they or their parent may die; experiencing separation anxiety when apart from the parent for even short periods

Strategies to help people cope:

1. Making social connections, by seeking support from someone or meeting up with others
2. Returning as soon as possible (as much as possible) to a normal schedule
3. Trying to find something practical that you can do to cope better right now
4. Doing all the things that are good for one's health in "normal" times (now they are more important to do), including:
    a. Getting adequate rest, nutrition, and exercise
    b. Engaging relaxation techniques, such as meditation, soothing music, calming self-talk, and breathing exercises
    c. Taking breaks
    d. Scheduling pleasant, fun activities
5. Attending a support group
6. Keeping a journal
7. Seeking counselling
8. Engaging in sports, hobbies, and creative activities
9. Thinking about the loved one who has died, and especially, happy times with them

Strategies that don't help people cope:

- Constant avoidance of talking or thinking about the event or the loved one's death
- Engaging in violence or conflict
- Blaming oneself or others
- Using alcohol or drugs
- Workaholism
- Not looking after oneself, and especially, doing risky things like driving recklessly or abusing substances

- Eating unhealthy food, or eating too much or too little
- Excessive use of television or computer/video games
- Withdrawing from friends, family, and formerly enjoyed activities

Tips for relaxation

Anxiety and tension, so prevalent after disasters, make it harder to cope just when more personal resources are needed to get through. The Rx for action is taking a moment, possibly multiple times during the day, to do activities designed just to help you relax. Calming can help you to concentrate, sleep, and have energy to deal with the many challenges you are suddenly facing. Some common relaxing activities include:

- Yoga, Pilates, and stretching
- Meditation and prayer
- Spending time in nature
- Exercising, especially exercise such as swimming
- Listening to soothing music
- A warm bath with relaxing herbs such as lavender (not always possible)
- Breathing exercises. A well-known one is very simple:
    1. Inhale slowly through the nose, filling your lungs and belly.
    2. Say to yourself: "I am filled with calmness."
    3. Exhale slowly through the mouth.
    4. Say to yourself, "I am releasing all tension."
    5. Repeat five times slowly.
    6. Do as many times per day as necessary.

For children, the *Psychological First Aid Field Operations Guide* recommends the following to lead a child through a breathing exercise: "Let's practice a different way of breathing that can help calm our bodies down.

1. Put one hand on your stomach, like this [demonstrate].
2. Okay, we are going to breathe in through our noses. When we breathe in, we are going to fill up with a lot of air and our stomachs are going to stick out like this [demonstrate].
3. Then, we will breathe out through our mouths. When we breathe out, our stomachs are going to suck in and up like this [demonstrate].
4. We are going to breathe in really slowly while I count to three. I'm also going to count to three while we breathe out really slowly.
5. Let's try it together. Great job!" (Brymer et al, 2006, p 148)

With children, experiment with making it fun, such as by blowing bubbles together (say with dishwashing liquid and bubble wands, or with bubble gum), or play games where the winner has blown something – even a wad of paper – across a "finish line" at the other end of the table (Brymer et al, 2006).

Alcohol and drug alert

Some people want to escape the physical, mental, and emotional reactions that they have after a disaster, and they also find their recovery challenges overwhelming. It is tempting to increase the use of alcohol or drugs to cope post-disaster, but substances are "false friends". While alcohol and drugs may temporarily deaden the stress response, they also create health and relational problems, interfere with deep, restorative sleep, and create dependence. If you suspect that your use of alcohol and/or drugs has increased since the disaster, or you are aware that you are having problems controlling it, it is very important to seek help with this. The main points to keep in mind spell the word, "**CONSULT**": what you must do as soon as you suspect you have substance issues:

- Consult a health care professional when you feel like using larger amounts of either prescribed or over-the-counter medications.
- Observe yourself, noting any changes in your use of alcohol and/or drugs
- Never use prescription and over-the-counter medications except as indicated.
- Seek support if you find that you have more trouble controlling your use of alcohol or drugs since the disaster.
- Use family, friends and others as supports to help you set up/maintain healthy habits, such as eating well, exercising and getting enough sleep.
- Liaise with a healthcare professional to help you find positive ways to deal with problems like anxiety, tension, depression, and sleep difficulties.
- Talk to your doctor or counsellor if you believe you have a problem with substance abuse.

For past issues with alcohol, drugs, or medications Some people who have been successfully recovered from substance addictions have strong urges to drink or use again after a disaster. Consciously choose to stay in recovery, using these tips as necessary:

- Increase your attendance at support groups.
- If your group is unavailable in the aftermath of the disaster due to broken community infrastructure, or perhaps you have been forced to re-locate, talk to disaster workers about helping you find a nearby recovery group. If none can be found, ask them to help organise a new one.
- Share with family and friends how they can best support you to avoid drinking or using.
- Increase your use of other supports that got you through without relapse in the past.
- Talk to your crisis counsellor, if you have one, about your past use.
- If you have a substance abuse counsellor or 12-step sponsor, talk to that person about what is happening for you. (Framework adapted from Brymer et al, 2006).

List of Organisations

Below are useful organisations to contact in order to find out more about emergency disaster response training, including Psychological First Aid field exercises. Some of the included organisations deal with the mental and emotional health of people, especially after a disaster or traumatic event. Some organisations are international, but many are located within Australia.

Organisations with a presence in Australia

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

Australian Centre for Posttraumatic Mental Health (ACPMH)
www.acpmh.unimelb.edu.au

Australian Psychological Society (APS)
www.psychology.org.au

Australian Red Cross
www.redcross.org.au

Beyondblue
www.beyondblue.org.au

Department of Human Services (DHS), State Government of Victoria
www.dhs.vic.gov.au/emergency

Department of Health (Queensland)
www.health.qld.gov.au/mentalhealth/useful_links/disaster.asp

Disaster Response and Resilience Research Group, University of Western Sydney
www.uws.edu.au/disaster_response_resilience/disaster_response_and_resilience

Emergency Management In Australia
www.ema.gov.au

Psychosocial Support in Disasters Portal
www.psid.org.au

Organisations which operate internationally

Inter-Agency Standing Committee (IASC)
www.humanitarianinfo.org/iasc

International Committee of the Red Cross (ICRC)
www.icrc.org

International Federation of Red Cross and Red Crescent Societies (IFRC), Psycho-social Support Reference Centre
http://psp.drk.dk

National Center for PTSD
www.ncptsd.va.gov

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

National Institute of Mental Health (NIMH)
www.nimh.nih.gov

Sphere Project for Minimum Standards in Humanitarian Response
www.sphereproject.org

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

World Health Organization (WHO)
www.who.int

(List compiled by Australian Red Cross and Australian Psychological Society, 2010)

Concluding thoughts

This course has taken us on a journey: from our comfortable armchair position of thinking that it would be nice to help out all the way to the centre of the disaster, or rather, its aftermath. We have asked you variously to be in roles of the psychological first aider, the government official, and also the survivor. By way of concluding, let us ask you to take up one more perspective: that of the journalist. Reporters must answer the "wh" questions to ensure that they have good coverage of an event, so let us do likewise as we reflect on what we now know about the unique form of assistance known as Psychological First Aid.

Who: YOU, as helper (or if you are unlucky, as survivor-client), and potentially any other human being walking around on the planet. Disasters are no respecters of persons, and Psychological First Aid is a person-to-person deal.

What: A flexible, respectful, culturally sensitive way of offering whatever survivors need post-disaster, beginning with the practical, but with in-depth catering for psychosocial, emotional, and spiritual needs to be met as well.

When: Whenever a disaster strikes. How quickly can you pack your duffel bag and arrange a plane ticket?

Where: At the evacuation shelters, hospitals, family assistance centres, outreach mobile vans, and other sites where human beings congregate in order to be safe and get needs met after they have endured a catastrophic event. Do you mind sleeping on a cot in a tent with the common ablution blocks a three or four minute walk away? And P.S.: it looks like a war zone there.

How: Armed only with your solid listening and interpersonal skills, your self-care regimes, your course certificate (!), and your deep desire to be of service, you will arrive at the site and find out how to slot into the Incident Command System that is in effect during your deployment. It may be intense, gruelling, and unrecognisably different from any counselling, social work, or for that matter helping, that you have ever done. You may be doing tasks very different from what you were told when you signed up.

Why: Sorry. We can't answer this last one for you. Why on earth would you ever go from a comfortable, organised life, probably in the midst of relative affluence (if you are a middle-class Westerner) to a scene of discomfort, chaos, the ugliness of destruction, and abject, tragic need? Maybe you don't know why you want to go; there are lots of reasons why people do the things they do. But if you are being strongly impelled forward to this experience, let us take a punt. Perhaps you want to offer Psychological First Aid because you cannot resist the sublime call to compassionate service that is emanating from your noble human heart. If so, Godspeed you.

References

Australian Red Cross and Australian Psychological Society. (2010). *Psychological First Aid: An Australian guide.* Victoria, Australia.

Brymer, M.L. , Jacobs, A., Lane, C., Pynoos, R., Ruzek, J., Steinberg, A., Vernberg, E., & Watson, P. (2006). *Psychological First Aid: Field operations guide, 2nd Ed.* United States: National Child Traumatic Stress Network and National Center for PTSD.

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